CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

19 October 1996

White Paper to boost pharmacy services?

£100K available for joint research project

NACEP journeys beyond the Millennium

National Association of Co-operative Executive Pharmacists

47th Annual Conference

Update: does East beat West in herbal lore?

Element of dissent in New Horizon debate

Sants makes wholesale link with George Foster

Unichem in the frame for spectacle dispensing

Online at http://www.dotpharmacy.com/

If you don't stock NEW Proctocream HC – you won't be sitting comfortably.

Are your customers sitting comfortably or are they just uncomfortable about their pile treatment?

Well now there's NEW Proctocream HC the first over-the-counter treatment for piles to combine an anti-inflammatory (hydrocortisone) and an anaesthetic to help ease the swelling while it stops the pain – offering your customers a unique answer to the problem of painful piles. And at just £3.79, they'll get twice the benefits without it being double the price. With extensive point-of-sale and support material, NEW Proctocream HC will be making its presence felt, and with further activity later in the year, your customers will be left with no doubts as to the benefits NEW Proctocream HC can offer them. So when the question of painful piles is asked, the answer is simple – choose the dual action properties of NEW Proctocream HC.

Product Information. PROCTOCREAM HC Presentation: Proctocream HC, Hydrocortisone acetate 1% w/w and Pramoxine hydrochloride 1% w/w in a white cream base. **Dosage and administration:** Apply after bowel evacuation morning and night up to 4 times a day, with finger, on to affected area. For internal rectal use: Remove cap from tube and apply applicator. Squeeze tube to fill applicator and gently insert into rectum. Squeeze tube carefully to force cream into rectum. Wash applicator after each use. Not recommended for children under 18 years. **Uses:** Relief of pain, swelling, irritation and itching associated with uncomplicated internal and external piles. **Warnings:** Do not use for periods longer than 7 days. **Precautions:** Should not be used by patients with known sensitivity to pramoxine or other ingredients. Not to be used in pregnant or lactating women. Compatibility with barrier methods of contraception has not been demonstrated. Seek medical advice if symptoms worsen or do not improve within 7 days. Although uncommon, local burning or itching may occur. **For external use only. Legal category:** P. **Cost inclusive of VAT:** £3.79 **Product licence number:** PL 0036/0065 **Product licence holder:** Stafford-Miller Limited, Welwyn Garden City, Herts. AL7 3SP. **Date of preparation** Sept 1996.

Pharmacists will give a cautious welcome to the primary care White Paper unveiled by health secretary, Stephen Dorrell, on Monday. Moves to promote the wider and better use of pharmacists' skills are to be welcomed. However, ministers have been very good in recent years at patting pharmacists on the back for the services they provide, and have spoken much about untapped potential. Words, so far, have not been translated into the NHS funding needed to make businesses sufficiently viable to support the type of flexibility the White Paper envisages. The Department of Health has recognised, though, that the current legislative and contractual framework does not provide opportunity or incentives for pharmacists to use their skills to the full.

The White Paper at this early stage offers an opportunity to be exploited in conceptual terms, but is a potential nightmare to translate into working practice. LPCs are all too aware of the problems arising from those portions of the global sum currently subject to local negotiation. Health minister Gerald Malone made it clear last week that he wants to see more contracting devolved to a local level. If this ring-fenced money – so-called Part 2 funding – is where the Department is looking for its 'flexibility', then contractors are in for a rocky ride. But if Mr Dorrell is saying that he is willing to review aspects of the current contract and work with PSNC to develop a 'New Age' model in which pharmacists are paid for their existing supply function, and on top of that, can bid to supply professional services financed from Part 1 funding, then life could get interesting very quickly. It would mean pharmacists genuinely competing with other service providers across health authority boundaries. But to expect businesses to operate on an *ad hoc* year by year basis to match health authority budgets is unreasonable.

CHEMIST & DRUGGIST

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THE NEWSWEEKLY FOR PHARMACY

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REGULARS

The Government intends to introduce legislation to allow health authorities more flexibility when purchasing community pharmacy services. It also intends to change the legal restrictions preventing community pharmacists from gaining financial recognition for providing a higher standard of service

White Paper heralds changes

Proposals which could change the way community pharmacy services are provided and paid for are published this week in a White Paper, 'Choice and opportunity – primary care: the future'.

A second White Paper, to be published towards the end of the year, will set out practical measures aimed to support primary care professionals. The Government's legislative programme will be outlined in the Queen's Speech on October 23.

Health secretary Stephen Dorrell says: "For community pharmacists, the proposed changes will mean that regulations need no longer act as a ceiling to professional development."

New types of GP contract to be looked at

The Government intends to introduce legislation enabling different types of GP contract to be piloted, although there are no plans to change the basic arrangements for dispensing (by pharmacists or dispensing doctors) or prescribing.

Health authorities will also be able to make extra payments locally for GPs to develop specific medical services; the payments will come from the general cash limited services for hospital and community health services.

The White Paper comments that there are great opportunities for GPs to develop a wider range of services in primary care and that the distinction between what constitutes general medical services and provision of other services in a general practice setting is becoming increasingly blurred.

The present contract does not always promote the opportunities for GPs to combine with other professions, the paper says.

- *The Independent* on Tuesday said the proposals would leave the door open for private retailers to offer NHS family doctor clinics in shopping malls. It claims a 'leaked' background document shows that ministers plan to allow a wide definition of those who may offer GP services in pilot schemes, in that GPs or "other organisations" could apply to provide personal medical services.

The White Paper says that during the past year's debate on the future development of primary care, several themes emerged for taking community pharmacy forward. These include:

- making better use of prescribed medicines
- wider recognition of community pharmacy as the first port of call for minor ailments
- health promotion
- providing more advice on medicines to the primary care team and others.

One of the most significant barriers to these developments is the way current legislation constrains the range and standards of services and prevents them being tailored to local needs.

Pharmacists are obliged to meet national standards – no more and no less – so regulations can act as a ceiling to service developments as there is no legal basis for requiring a different level of service, the White Paper says.

In addition, any pharmacy meeting these requirements can provide any service, which could cut across local needs, making financial planning difficult and possibly making the service not cost-effective.

Health authorities have no power to make arrangements for services with a pharmacy outside their boundaries. Proposed legislation will allow them to decide which, where and how much of the prescribed service to purchase while sticking to a basic framework and only purchasing from NHS community pharmacy.

NHS community pharmacies could apply to provide these services from a local or neighbouring health authority. Patients' rights to take NHS prescriptions to the pharmacy of their choice would not be affected, nor would the legal controls and standards surrounding dispensing.

The secretary of state will set out the services which health authorities can buy locally. These might include help for individual patients or services directed at groups of patients or carers. Set criteria will ensure that services are to be provided only by those competent to do so.

The local services might also involve providing help and advice on medicines to other healthcare staff, within a framework of national minimum service standards. For example, a pharmacist providing medication review might be required to assess patients' medication in line with nationally specified criteria and to liaise with the GP.

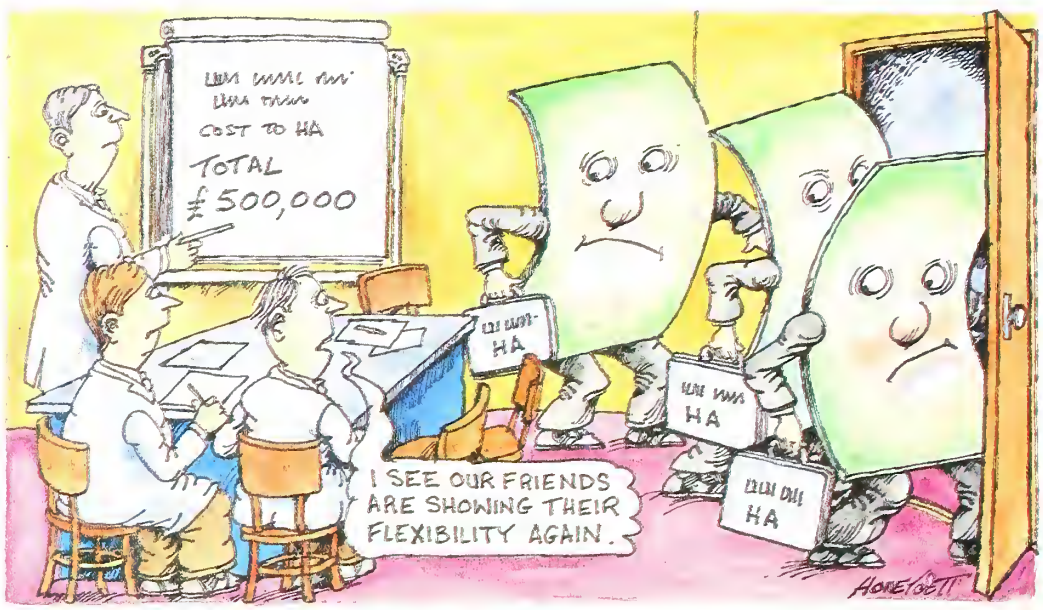
Health authorities could decide whether they wished to set their own guidelines and could prioritise services for different patient groups. The authorities could also consider how much of these services they wished to purchase, what local specifications to include and how much they proposed to pay.

The secretary of state will be able to set out the criteria to be followed in making these decisions, although the emphasis will be on meeting local priorities and needs.

Where authorities are buying services under Part I of the NHS Act 1977, such as needle and syringe exchange, they are obliged to use legally enforceable contracts. This has sometimes discouraged them from considering pharmacists as potential providers, the White Paper claims.

The Government believes there will be benefits in making these arrangements through NHS contracts, which are usually simpler and not enforceable by law, although they are subject to binding arbitration by the secretary of state.

Health secretary Stephen Dorrell



Proposals welcomed

The White Paper could open the way for patients and other health professionals to gain much improved access to pharmacists' advice on all aspects of medicines and their use, comments the Royal Pharmaceutical Society.

The president, Ian Caldwell, has broadly welcomed proposals to create incentives for health authorities to purchase a wider range of NHS pharmacy services.

"Pharmacy as a profession has shown its commitment to playing a fuller part in primary care: what we now need are the financial resources for pharmacy to deliver the new services," he says.

"Patients have the right to expect high-quality pharmaceutical services wherever they live. We have concerns that these proposals could create anomalies in terms of standards," he says.

"The Society will be pressing for national standards for these services to be established by the professional body and for input into discussions on the range of additional pharmaceutical services from which local authorities may select."

Mr Caldwell added that he would be seeking reassurance that the proposals would not undermine local provision of services: "The success of the local community pharmacy network is based on the fact that patients trust and benefit from the flexibility of locally-based pharmacy services."

The Society welcomed the assurance that patients would still have freedom of choice of pharmacy for dispensing.

£100K for research project

A sum of $100,000 is to be made available for work into the largest-ever research programme about community pharmacy.

'Pharmacists practising in a community pharmacy environment improve the overall health of the nation' is the basis of the joint research initiative put forward by a consortium of pharmacy organisations.

The consortium is made up from the Royal Pharmaceutical Society, the National Pharmaceutical Association, the Pharmaceutical Services Negotiating Committee, the Scottish Pharmaceutical General Council and the Company Chemists' Association.

The move follows a joint statement of intent by the five organisations, saying they were "committed to the principle of developing a strong research base to underpin future developments of practice and policy in relation to community pharmacy".

Research will focus on the public's use of community pharmacy as a primary healthcare source. It will also examine the role of pharmacists and their potential within the primary healthcare team.

Views to be aired over 'employee Union'

Employee pharmacists and locums are being asked for views on issues that could be tackled by an independent association of employee pharmacists.

One possible topic for discussion at a meeting on November 17 is whether any new association should be affiliated to a trade union.

Pharmacists who register for the meeting, to be held at the Strathallan Thistle Hotel, Edgbaston, Birmingham, from 2.00-5.00pm, will be sent a questionnaire to stimulate discussion on key issues affecting locums and employees. Representatives from the Guild of Hospital Pharmacists will talk about the services the Guild provides and its affiliation with the MSF union.

The Royal Pharmaceutical Society is facilitating the meeting, but Nicola Gray, chairman of the Community Pharmacists' Group, says it will be up to those present to decide whether to form an independent association and how it should operate.

Further details are available from Ms Janet Flint, practice division, RPSGB, 1 Lambeth High Street, London SE1 7JN. Employees and locums unable to attend the meeting are welcome to apply for a questionnaire so their views can be heard.

- The Young Pharmacists' Group has invited the TUC's general secretary, John Monks, to its annual meeting on October 26-27. YPG spokesman Joel Hirst told *C&D* it might make sense for an employee association to affiliate with a union which could address remuneration, working conditions and hours of service.

DoH writes to PSNC over remuneration

After several months' silence, the Pharmaceutical Services Negotiating Committee has at last received a letter concerning remuneration from the Department of Health.

The content, which has not been disclosed, was being discussed by the Committee at its monthly board meeting on Wednesday, as *Chemist & Druggist* went to press.

The letter was received two days after Mr Axon addressed delegates at the National Association of Co-operative Executive Pharmacists (see p547).

At this meeting, he thought that the letter would contain news about the global sum and "hopefully the advance payments system".

The final solution

Joe King, who owns three pharmacies in Norfolk, was faced with demolishing a partly-built premises this week after a three-year wrangle with his district council.

Building work had begun on his Mulbarton Common pharmacy before he discovered the site was on common land. He is suing his solicitors for alleged negligence in giving him the wrong advice.

Headlice was the subject of the last week's *Chemist & Druggist* training seminar, sponsored by Seton Healthcare. Over 70 pharmacists and staff gathered at the Elstree Moat House to hear presentations from leading UK expert Dr John Maunder (left), director of the Medical Entomology Centre in Cambridge; Elaine Barlett, principal pharmacist in community health at the University Hospital Birmingham NHS Trust; and community pharmacist and CPPE tutor Michael Fagan (right). The event was chaired by *C&D*'s editor, Patrick Grice. A synopsis of the three presentations appears on pp553-556

Tesco pharmacy applications turned down

Two pharmacies have been refused permission to move into Tesco's superstore in Southampton Road, Salisbury.

Tesco had hoped to test the recent 'Tucker' High Court decision on what constitutes a 'neighbourhood'. But Wiltshire Health Authority has decided that there have been no material changes in the neighbourhood since the Appeal Authority turned down an application from one of the pharmacies (Kalix of Shrewsbury) in December, 1994, so the court decision did not apply.

The HA noted that none of the Salisbury doctors was in the same neighbourhood as the Tesco store, to which access was mainly by car. The neighbourhood consisted mainly of industrial premises with little residential development. Although there was no pharmacy, the authority's pharmaceutical committee felt it was not necessary to grant the application to secure adequate provision of pharmaceutical services.

The authority received 300 letters – 12 against and 288 supporting the application – due to Tesco making available leaflets and stamped addressed envelopes.

A relocation application from Dennis Moore, who owns pharmacies in Salisbury, was turned down on the grounds that none of his pharmacies was within the neighbourhood of the Tesco stores' site.

Frank Courie, Tesco's pharmacy development manager, told *C&D* that Mr Moore's application for a relocation had a lot of merit and the company would make strenuous efforts on his behalf if he decided to appeal, although neither of the applications was under Tesco's control.

Schering Award

The College of Pharmacy Practice is seeking nominations for the 1996 Schering Award. Nominations should be sent to the administrator, CPP, University of Warwick Science Park, Barclays Venture Centre, Sir William Lyons Road, Coventry CV4 7EZ by December 31. Entries should include a supporting statement of 1,000 words.

Partnership in Healthcare

Labour health spokesman Kevin Barron will be addressing the 'Partnerships in Healthcare' conference being hosted by the PSNC, the RPSGB and the Pharmaceutical Advisors Group on November 7 at the Metropole Hotel, Birmingham. Inquiries to Geraldine Cato at PSNC, Aylesbury.

Panel confirmed

The speakers on the panel session at the Scottish Pharmacists Conference on October 27 in Stirling have been confirmed as Dr James Dunbar of the Dunhill practice in Dundee; community pharmacist Andrew Maguire from Dunkeld, Perthshire; and Karen Lockhart, a senior nurse at Gartnavel Hospital. Contact Dr L Howden at the RPSGB Scottish Executive.

NI script figures

Chemists and appliance suppliers in Northern Ireland dispensed 1,682,717 items (1,003,289 forms) during July. Net ingredient costs were £15,093,951 (discount 6.419 per cent), and the gross cost £17,776,528. The amount received for prepayment certificates was £74,106.

PHS leaflet

A new leaflet, 'Medicines – made to measure', outlining effective medicines management for the elderly and their carers is now available from the Pharmacy Healthcare Scheme on 01222 681262. A fee of £2.50 will be charged for p&p.

Script update

The Prescription Pricing Authority has clarified how exemption arrangements on the new FP10 and FP14 forms are dealt with. If a patient signs to claim exemption in part C, but hasn't entered a cross in the relevant exemption box, the PPA will accept the form as exempt. A rubber stamp and/or a facsimile signature is not acceptable in lieu of a written signature. Forms submitted in this way will be treated as chargeable by the PPA.

Outreach project for Norfolk

Norfolk pharmacists are taking part in a £30,000 pharmacy outreach project, making domiciliary visits to patients referred by GPs, social services and other healthcare professionals.

The pharmacists make an initial home visit to discuss with the patient or carer the medicines being taken, the importance of taking them and the correct storage. They devise a pharmaceutical care plan and refer problems to the doctor or social worker. After a few weeks, the pharmacists call again to review the situation.

Norfolk Social Services is funding the six to eight-month pilot, which is being run in collaboration with North West Anglia and East Norfolk Health Authorities and Norfolk Local Pharmaceutical Committee. If the initial project is successful, social services hopes to attract funding from the HAs to continue and expand the scheme.

The nine pharmacists each received £150 to cover a six-hour CPPE training course and attendance at other meetings. The initial one and a half-hour consultation attracts £15 an hour for the pharmacist and £15 an hour for a locum, plus travelling expenses. There is a £20 fee for the half-hour follow-up and £20 if monitored dosage systems are provided.

Norfolk LPC secretary, Pam Meakin, told *C&D* it was expecting to help about 20 patients per pharmacy, mostly the elderly, people with learning difficulties or those with mental illness.

Tim Hawley, service development officer for adult care at Norfolk Social Services, explains: "The project has been set up to help clients who are at risk of losing the independence of living at home because they find taking complex amounts of medicine too confusing and may be putting themselves at risk."

Welsh Prescribing Authority problems

Staff shortages at the Welsh Prescribing Authority are causing problems for Welsh pharmacists.

The Welsh Central Pharmaceutical Committee has warned that if payments are not brought up to date soon, the service to patients could be jeopardised.

Committee member Peter Jenkins explained that pharmacists in the five health authorities were receiving 100 per cent payments on a rotation basis. The estimates were based on the previous month, then adjusted mid-month, so pharmacists were having difficulty balancing their books.

The Committee has also written to the Welsh Office seeking a reduction in the cut-off point above which pharmacists can claim quicker payment for expensive items.

Another plan is to establish a formulary of medicines likely to be used in emergencies. Arrangements would be made for pharmacists to keep these medicines in stock and for GPs, where possible, to order from that list.

Patient packs delay

No firm date has yet been agreed for the official start of the patient pack initiative.

The patient pack joint working group, which represents all interested parties, reconvened last week to review the current position. The Royal Pharmaceutical Society's representative, Roger Odd, told *C&D* it was hoped that a target date might be set in a document to be published at the end of this month, giving joint proposals on how the scheme should progress.

The health minister, Gerald Malone, said recently that the dispensing and reimbursement arrangements, which would make the initiative effective for patients, could not be phased in until February or March, 1997.

Mr Odd thought the main reason for delay was the Department of Health's concern over costs, as well as lack of agreement over pack sizes. Progress was being made in several areas, but there was still a lot of work to be done. The working party had tentatively agreed that, when the scheme was ready to go forward, there would be an updated launch to inform the public, industry and professions.

Pharmacists were now concerned that delays were causing shortages of some drugs, he added.

Brunton sentenced

Edinburgh pharmacist James Brunton has been sentenced to 240 hours' community service.

Mr Brunton, who was sentenced on Wednesday, had been found guilty of illegally supplying £30,000 of prescription drugs from his pharmacy (*C&D* September 21, p385).

Sentence had been deferred twice while background and community service reports were carried out.

Sheriff James Farrell, who heard the case, had already warned Mr Brunton: "You must bear in mind the prospect of a prison sentence."

Schaffer affair claims yet another 'victim'

A pharmacist who acted as a wholesaler to a 'rogue' has been reprimanded by his professional body.

Shirazali Panjawani, the sole owner of Jethro's Chemist, Golders Green, London, was fined £4,500 with £1,000 costs at Wood Green Crown Court in January this year, when he was convicted on three counts of wholesale dealing without a licence between December 2, 1992, and September 9, 1993.

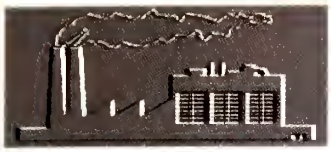
The Statutory Committee of the Royal Pharmaceutical Society last month heard he had supplied £76,000 of licensed medicines to Pierre Schaffer. Mr Schaffer has featured in a number of hearings involving pharmacists who purchased unlicensed and imported products from him at bargain prices.

Mr Panjawani was at the time, but no longer is, a partner in Jetsol Chemists, Canning Town, London. A wholesale licence was in existence for that business – but not for Jethro's – which is where most of the sales to Mr Schaffer were made.

A wholesale licence is not needed if the sales amount to an 'inconsiderable' proportion of a pharmacist's business. However, it was found the purchases amounted to 11 per cent of Mr Panjawani's pharmaceutical sales.

Committee chairman Andrew Hillier said that although "in principle" the offence warranted a striking off, it was "not appropriate" to do so. Reprimanding Mr Panjawani, Mr Hillier said the Committee had taken into account no patient had come to any harm.

INDUSTRY VIEWPOINT



Topical Reflections

Unipath on the horns of a dilemma

Unipath's decision to launch its Persona fertility test exclusively with Boots has deservedly incited much comment and criticism. There is no doubt that 'knives are being sharpened' and that Unipath will experience the anger felt both by other multiple pharmacies and independents in their day to day trading activities.

Yet the dilemma faced by Unipath is common to all who launch new products into the pharmacy sector. While Boots is renowned for its negotiation tactics, the company can provide exceptional support in-store, with guaranteed distribution, space on-shelf, promotional activity and pharmacist and staff training.

By comparison, it is a slow and expensive process to launch a new product into the independent sector. At best, a manufacturer can gain the enthusiastic support from most retail pharmacists for a launch programme that is well funded and personalised to the unique trading environment of community pharmacies.

At worst, the manufacturer can experience indifference, hostility, or just plain apathy. Costs can be prohibitive. A single representative call to 8,500 pharmacists will normally cost more than £500,000 and to provide a comprehensive support service costs much more. And that's before marketing costs are taken into account.

It is an expensive exercise for large companies and often prohibitive for smaller manufacturers. While alternative options, such as mail shots, can be cheaper, they are often less effective in gaining pharmacists' active support for a new product launch.

Yet independent pharmacists have a unique opportunity to negotiate on equal terms with Boots, and even to gain exclusive distribution agreements. Manufacturers do gain strong promotional support for product launches through agreements with Numark, the AAH Vantage and Unichem Gold Partner schemes, and others.

However, this often falls short of guaranteed distribution and in-store support. If independent pharmacists were prepared to make greater commitments to their trading organisations, manufacturers might be less inclined to enter into exclusive agreements elsewhere.

This column is contributed by a senior industry manager.

Taking the tablet – a lousy solution?

This year the headlice problem seems greater than ever, and with carbaryl now a POM, the reports of treatment failure are increasing. It is difficult to know what to suggest as an alternative, but perhaps the world of veterinary medicine may have the answer.

However, it is not lice but fleas that preoccupy the thoughts of animal lovers, and the pharmaceutical industry has come up with a novel alternative to organophosphorus insecticides. A simple oral tablet that inhibits the growth of the flea appears to provide effective and safe control.

I do not know whether the physiology of the head louse makes it susceptible to this advance in veterinary medicine, but I certainly look forward to the day when a co-ordinated national campaign of a single dose head louse tablet could once and for all eliminate this scourge.

It remains to be seen, however, whether the industry, presently thriving to the tune of £1.4 million a year in producing headlice lotions, will be so enthusiastic!

The right antidote to poor margins

I recently had a meeting with my accountant, at which he expressed amazement at the poor gross profit I achieve on my business. In particular, he looked at the professional services I offer in promoting OTC medicinal sales and was then not very polite in suggesting that someone was paying peanuts to monkeys!

Unfortunately, I know he is right, but he acknowledged that I am in a weak position when it comes to improving profit margins while, conversely, the profits achievable in industry can be huge.

A good example is last week's announcement that Seton Healthcare has just paid the London International Group £3.5m for the Far East rights to Woodwards, which last year achieved a profit of £1.3m on sales of £2.3m. Huge profit margins indeed!

Another example, and this time closer to home, is Paradote, the paracetamol and methionine formulation from Penn Pharmaceuticals. Penn emphasises the importance of professional input in selling a paracetamol tablet containing its own in-built antidote; but if I buy at standard trade terms, I will make 37p on each properly-counselled sale (26 per cent POR).

This is a laughable reward for such a professional service, but to put the profit element into perspective, Penn is happy to reduce its profit by 39p per 24 tablets when a pack of 96 is sold or to offer a 'four for the price of three' trade offer if 48 x 24 are purchased.

The inherent manufacturing margins are large, and not ones I can enjoy. I would like to encourage the sale of Paradote, but not at the margins being offered.

I calculate a flat rate price of 49p per 24-tablet pack to be perfectly reasonable and I could then sell in sufficient quantities to make both my sales, and those of Penn, financially and professionally worthwhile.

Nice try – but no thanks!

I have just received my letter from Steve Hall, UK sales manager for Unipath, in which he tries to justify his company's decision to direct my customers to Boots.

I read the letter once, then again more slowly, because I really could not believe its contents. Here was Mr Hall trying to elicit my co-operation for future sales by implying that if I did not join his training programme, I would be excluded from selling the real money-makers – the monthly pack of test sticks needed by each customer.

He then continued, without any hint of an apology, stating that Boots has been given a sales monopoly.

Who does Mr Hall think he is? For reasons still unclear, Unipath has sold its soul to the highest bidder. If Mr Hall thinks he can now blackmail me into supporting his company, he will be sadly mistaken.

I made my position crystal clear in last week's column and his letter merely reinforces that decision. However, I am sure the lesson of this disaster will not have been lost on Unipath's competitors!

Comfeel Seasorb

Coloplast has renamed its alginate dressings Comfeel Seasorb. The company's alginate filler dressing will retain its name. Comfeel Seasorb is available on the Drug Tariff.
Coloplast Ltd. Tel: 01733 392000.

Progynova packs

Single packs of Progynova 2mg (28 tablets) will be replaced by triple packs in October and single packs of Progynova 1mg will be replaced in early November. The basic NHS prices will be £7.02 for both.
Schering Health Care Ltd. Tel: 01444 232323.

Ronicol Timespan 150mg

Ronicol Timespan 150mg is currently out of stock. However, Tillomed Laboratories would like to point out that the 25mg and 100mg tablets are unaffected.
Tillomed Laboratories Ltd. Tel: 01462 480344.

Ung Merck goes blue

Merck Dermatology will be phasing in new blue pack designs for Unguentum Merck from November.
E Merck Pharmaceuticals. Tel: 01895 452200.

Cox's own Timolol

Cox has launched generic Timolol Eye Drops 0.25 per cent (5ml, basic NHS price £5.18) and 0.5 per cent (5ml, £5.82).
Cox Pharmaceuticals Ltd. Tel: 01271 311200.

Generic sulpiride

APS/Berk has added sulpiride 200mg tablets (100, basic NHS price £18.53) to its list of generic drugs.
APS/Berk Pharmaceuticals Ltd. Tel: 01132 380099.

Elantan LA

Schwarz Pharma's Elantan LA capsules have changed colour. Elantan LA25 is now brown and white and Elantan LA50 is brown and flesh-coloured.
Schwarz Pharma Ltd. Tel: 01494 772071.

Evans' repack

Evans is repacking Minijet over the next 18 months to make it easier to identify the product and strength. Evans has also redesigned packs in its diamorphine and morphine sulphate range.
Evans Medical Ltd. Tel: 01372 364000.

New HIV protease inhibitor

Invirase (saquinavir 200mg) is a new selective and highly-potent HIV protease inhibitor from Roche, which has shown minimum cross-resistance to other drugs of that class.

Saquinavir is indicated for use in combination with antiretroviral nucleoside analogues in the treatment of HIV-1-infected patients with advanced progressive immunodeficiency.

Studies have shown it to be well tolerated and to have significant antiviral activity. In one study, two-thirds of patients saw an increase in CD4 cell counts and almost 90 per cent had a fall in viral load. Over six months, only 5 per cent discontinued treatment due to side-effects.

Resistance to saquinavir has been shown to develop slowly and at a low frequency compared to other protease inhibitors, even during prolonged therapy and at doses four times greater than those used in clinical trials. The incidence of mutations in the HIV protease gene is also lower in combination therapy compared with monotherapy. Saquinavir has even been shown to delay zidovudine resistance.

Cross-resistance with other protease inhibitors is also rare because mutations occur at different sites on the HIV protease genome. This means saquinavir should ideally be used as a first-line protease inhibitor to keep "future treatment options open", says Roche.

Dose: 600mg three times a day within two hours after a meal (absorption enhanced by food). Discontinue if saquinavir-related toxicity appears – dose of less than 600mg three times a day is not recommended. No initial adjustment is needed in mild to moderate hepatic or renal impairment. No studies into dose adjustment for severe impairment have been carried out, but caution must be exercised.

Contra-indications: hypersensitivity to saquinavir.

Precautions: patients may still acquire illnesses associated with advanced HIV infection, such as opportunistic infections; toxicities associated with co-administered drugs may be experienced. The safety and efficacy of saquinavir in the young, elderly and patients with chronic diarrhoea or malabsorption has not been established. There are no human data supporting safety in pregnant and lactating women; breastfeeding should be discontinued prior to drug administration. Haemophiliac patients should be aware of the possibility of increased bleeding.

Interactions: none with concomitant use with zalcitabine and/or zidovudine. Rifampicin (600mg daily) decreases plasma concentrations of saquinavir by 80 per cent and concomitant use is not recommended. Drugs which induce or inhibit CYP3A4 should be borne in mind with doses adjusted where necessary. Concomitant use of saquinavir with ritonavir is not recommended as there is insufficient data on safety and efficacy.

Adverse effects: frequently – rash, headache, peripheral neuropathy, diarrhoea, abdominal discomfort, buccal mucosa ulceration and asthenia. Single, rare cases of serious adverse effects are listed in the Summary of Product Characteristics.

Packs: bottle of 270 capsules, basic NHS price £331.28.

Roche Products Ltd. Tel: 01707 366000.

Zyprexa superior to haloperidol

Lilly's Zyprexa (olanzapine) has been shown to be significantly more effective than haloperidol in treating overall and negative symptoms of schizophrenia, as defined by the Brief Psychiatric Rating Scale.

Studies supporting the recent launch of Zyprexa (*C&D* October 5, p456) have also indicated it to be as effective as haloperidol in treating the positive symptoms and to be superior in improving the associated depressive symptoms.

Olanzapine, a new pluri-potent atypical antipsychotic, is chemically and pharmacologically distinct from other antipsychotics, with affinities for serotonin, muscarinic and, to a lesser extent, dopamine sites. This is thought to lead to its significant efficacy and low propensity to cause extrapyramidal side-effects.

Eli Lilly & Co Ltd. Tel: 01256 315000.

Losec 40mg community packs

Astra is introducing a seven-capsule blister pack of Losec 40mg for community pharmacists.

The new pack (basic NHS price £17.72) replaces the 14-capsule bottles, which will be discontinued when stocks are exhausted. Returns for credit will not be accepted by Astra as any old packs should be dispensed as usual. Hospitals will be supplied with seven-capsule bottles until further notice.

The administration time of Losec 40mg for prophylaxis of acid aspiration has also changed to one 10mg capsule to be taken on the evening before surgery followed by another capsule two to six hours prior to surgery.

Astra Pharmaceuticals Ltd. Tel: 01923 266191.

A&H's Ventolin tablets to be discontinued

Allen & Hanburys will be discontinuing Ventolin Tablets 2mg and 4mg from the end of October.

The company has recommended patients be switched to either Serevent Inhaler (salmeterol) or Volmax Tablets (controlled-release salbutamol).

Both alternatives are thought to provide an improvement in therapy over the original tablets because of their longer duration of action. Serevent prescribed in the Accuhaler is recommended for patients who find inhaler co-ordination a problem.

Discontinuation switch packs, which include patient information leaflets, are available from customer services on 0800 221441.

Allen & Hanburys Ltd. Tel: 0181 990 9888.

"The biggest analgesic launch for the past 10 years"

- Massive £6.4 million advertising and promotional package, including national TV, press, posters and PR.
- Full range of 200mg and 400mg variants.
- Striking promotional material directing customers to 'Ask your Pharmacist' about Advil*
- Highly attractive PORs.
- Full range of point of sale material available, ready for TV in November.

Whitehall Laboratories, Huntercombe Lane South, Taplow, Maidenhead, Berkshire, SL6 0PH
*A Trade Mark

COUNTERpoints

Base line

Mavala has relaunched Barrier Base, its base coat for nails. It is formaldehyde-free, durable and offers moisturising protection (10ml, £8.60).
Mavala UK Ltd.
Tel: 01732 459412.

Africa hits Superdrug

Africa, the exotic fragrance by Sophie Nicholas, is to be sold through over 600 Superdrug stores nationwide. Launched last October, it was previously exclusive to Boots.
The Sales Company.
Tel: 01763 848292.

Major spend by Braun

Braun is supporting its range of electrical appliances during the winter/Christmas season with a £7,380,000 TV and press advertising campaign, including a £6,750,000 spend for 1996. Braun is supporting TV advertising with four advertorial campaigns.
Braun (UK) Ltd.
Tel: 01932 785611.

Barielle ad first

The Select Cosmetics Company is launching its first advertising campaign for Barielle, its nail care range. The campaign will appear in November and December issues of selected women's magazines. Barielle's entire range is devised from a cream initially used to treat the hooves of horses. The range includes a collection of treatments for nails, hands and feet.
The Select Cosmetics Co Ltd. Tel: 0171 935 5988.

Predicting a bonus

Chefaro UK is offering stock bonus deals on Predictor home pregnancy kits up until Christmas. The deals are available direct to the pharmacy through Chefaro representatives or by calling Chefaro direct.
Chefaro Proprietaries Ltd.
Tel: 01233 420956.

Vital Eyes opens new market

Ciba Vision has opened up a new sector in the eye care market, with the launch of Vital Eyes eye 'conditioner' drops.

The eye drops (10ml, £3.49) are unlicensed and are positioned as a daily beauty care product for moisturising tired and dry eyes. Vital Eyes is a non-astringent lotion, enriched with vitamins A and E.

One or two drops should be applied to each eye when needed. Brief blurring of vision may be experienced due to the moisturisers contained. As with all eye drops, the pack should be discarded a month after opening. Vital Eyes should not be used while wearing soft contact lenses.

Ciba Vision is supporting the launch with a £500,000 press advertising campaign in November, followed by a £1.5 million TV campaign breaking next February. Sampling and educational support are also planned.

Vital Eyes are the first eye drops not to be restricted by a P or GSL licence. The launch follows consumer demand for a non-medical product which is safe for everyday use against common eye irritations.
Ciba Vision (UK) Ltd.
Tel: 01489 785399.

Direct action on sore throats

Crookes Healthcare has extended its Strepsils range with the launch of a new, anaesthetic throat spray. Strepsils Direct Action Spray (£3.99), a P product containing 2.6mg of lidocaine hydrochloride in each spray, is indicated to relieve severe sore throats.

For one dose, adults and children over 12 are advised to aim the nozzle at the back of the throat and spray three times. This can be repeated every three hours as required to a maximum of six doses in 24 hours. The spray is not recommended for children under 12 years or patients suffering from asthma or bronchospasm.

The spray can cause allergic reactions and as

patients may experience numbness of the tongue, they should take care when eating and drinking hot foods.
Crookes Healthcare Ltd.
Tel: 0115 953 9922.

Senokot makes a TV comeback

Reckitt & Colman is backing Senokot with a £500,000 TV advertising campaign.

It will break on November 4 on terrestrial TV in London, Central, North and North West regions, running for three weeks. This will act as a pilot with a view to a national campaign next year.
Reckitt & Colman Products. Tel: 01482 326151.

Vital work by Vitabiotics

Vitabiotics is supporting the National Osteoporosis Society with a donation of £0.10 for every special pack of Osteocare tablets sold.

The NOS is the only charity raising funds exclusively to improve diagnosis, treatment and research into preventing osteoporosis.

The support should initially raise £20,000.
Vitabiotics Ltd.
Tel: 0181 963 0999.

Putting new fizz into Alka-Seltzer

Bayer has repackaged Alka-Seltzer in time to launch its annual winter offensive.

Packaging now features new graphics which allow the box to stand on either edge on the shelf, and fit any size of facing. The pale colour of the old-style packs has been exchanged for a bright blue, with red and yellow boxes to identify Original or Lemon variants.

Alka-Seltzer will now be available in packs of ten and 30, priced at £1.85 and £2.99 respectively. Each contains sachets of two-tablet doses.

The packaging has been designed to appeal to a wider audience – from the younger, maybe suffering from a hang-over, to the housewife needing indigestion relief.
Bayer plc.
Tel: 01635 563000.

Nicobrevin gets an overhaul

Robinson Healthcare is relaunching Nicobrevin, the 35-year-old nicotine-free smoking cessation product, with a redesigned pack.

Nicobrevin is produced as a 28-day course of tasteless and odourless capsules, and offers a nicotine-free alternative to other smoking cessation products.

In one clinical trial, 62 per cent of smokers who used the product completed the course without smoking, according to the company.

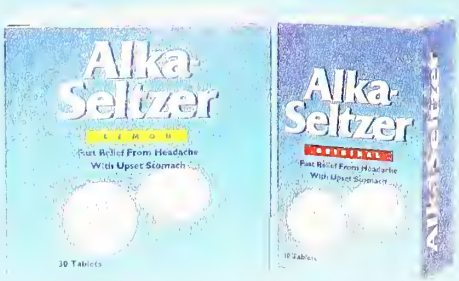
Robinson is planning a national advertising campaign in major national newspapers in March to coincide with national No Smoking Week.

The new packs will be available in pharmacies from November.

Robinson Healthcare.
Tel: 01246 220022.

CLINK CLINK

Our Christmas presence on TV this year is guaranteed to perk up sales. They've risen to 43% in the past three years during the TV period. Not only that, the TV campaign is the best ever and we've got some brand new wrapping. So put some in your stocking and, like your customers, enjoy an extremely Merry Christmas.



Be beautiful with Belle Color Colorease Gel for the home

Laboratoires Garnier has launched Belle Color Colorease Gel, its new hair colorant.

Belle Color is designed for home use, and contains a formulation that helps to provide a permanent colour change in 20 minutes. A sachet of After Colour conditioning shampoo is also included in the carton.

Belle Color is formulated to be gentle on the hair, and combines 'Essence of Nature', a fruity-fresh aromatic oil, to make hair colouring a more pleasurable experience, with jojoba and wheatgerm oil to promote healthy, shiny hair.

Belle Color is available in 20 shades, varying from light pure blonde, chestnut brown, right through to black (100ml $4.29).

Laboratoires Garnier.
Tel: 0171 937 5454.

Bronnley's collection of Christmas creations

Bronnley has launched a new collection of soaps, toiletries and perfumes for Christmas.

This year's collections combine a variety of gift sets.

Almond Oil is a range of gift sets varying from $2.95 for a box of fragrance guest soaps to $45 for a gift basket, which comprises three hand soaps, bath foam, hand and body moisturiser, shower gel, eau de toilette, dusting powder and bath seeds.

The sets are available in a selection of fragrances, including English Fern, Camellia, Pink Bouquet, White Iris, Blue Poppy and Lavender.

English Country Herb gifts are presented in wooden buckets containing soaps, bath seeds and pot pourri.

Novelty Gifts comprise of a selection of animal soaps in bear, owl and rabbit shapes.

Classic is a floral and fruit fragrance with ozonic overtones. It is available in a variety of gift coffrets, ranging from $19.95 to $29.95 for a set which includes a Classic hand soap, moisturising body spray and eau de toilette.

H Bronnley & Co Ltd.
Tel: 01280 702291.

Dreamy male fragrance from Gianni Versace

Aspects Beauty Company is launching The Dreamer, its new male fragrance from Gianni Versace, from November.

It incorporates top notes of juniper, artemisia and tarragon; heart notes of amber lily, iris roots and linen essence; and base notes of tobacco flowers and amber.

The Dreamer is available in eau de toilette splash (50ml, £29) and eau de toilette spray (50ml, £31 and 100ml, £43).

A grooming range, including aftershave lotion, aftershave balm, foaming gel for hair and body, deodorant natural spray and deodorant stick, will follow.

Aspects Beauty Company.
Tel: 01273 400085.

Lipsmacking news from Larkhall

Larkhall Green Farm is backing Lipcote, its transparent sealer for lipstick, with a $500,000 spend.

The product features new packaging and is backed by an advertising campaign targeted at teenage and women's magazines. Advertisements have the strapline, 'When everything else comes off, Lipcote stays on'.

Lipcote (7ml, $3.20) has a brush-on applicator and dries to form an invisible seal that locks in lipcolour.

Larkhall Green Farm.
Tel: 0181 874 1130.

Giving hair new Living Joy

New to the UK is Living Joy Haircare by Michael Lipman.

The range comprises 17 different products, all of which contain UV sunscreens, and work to help moisturise and strengthen the hair as it is styled. Products also help to prevent hair breakage and split ends, according to the company.

The range is packaged in biodegradable bottles, and includes:

- shampoos – Body Builder/Therapy/Purity (2oz, $1.25 and 8oz, $4.95); and Shimmer (4oz, $4.25 and 16oz, $8.50)
- conditioner – Moisture Loc (2oz, $1.60 and 8oz, $5.95); and Equaliser (4oz, $4.25 and 16oz, $8.50)
- treatments – Kelp Help treatment (4oz, $5.95); plus Fortress and Rescue treatment (4oz, $6.50)
- styling – Jelly Whip (7oz, $7.50); Jelly Bean, Fruit Gum and Slip 'n' Glide (2oz, $1.60; 8oz, $5.95 and 16oz, $8.50); and Hydra Hold (4oz, $4.25 and 16oz, $8.50)
- finishing – Reflexion and SOS Shine (4oz, $7.50); and Final Fixx (4oz, $4.25 and 16oz, $8.50).

Michael Lipman.
Tel: 0181 554 0867.

Recipe for healthier hair

New Healthy Hair Recipe cards are now available free in-store alongside Pantene Pro-V styling products.

The cards outline the ingredients required to create certain styles, including products and tools, and also show a step by step method of how to create the look.

Currently there are over 1,500 styling products on the market and research by manufacturer Procter & Gamble has shown that it's difficult for the consumer to know what product to use and how.

A print advertising campaign with a spend of £90,000 will promote the Healthy Hair Recipes in December issues of health, hair and women's magazines.

Procter & Gamble is investing £5.75 million on advertising for Pantene Pro-V over the year July, 1996, to June next year.

Procter & Gamble (Health & Beauty Care) Ltd.
Tel: 01932 896000.

Collection 2000 cosmetics go chocolate crazy

Collection 2000 has launched Chocolate Delight, its new limited edition make-up range.

It will be available up until Christmas, and features metallic, matt and frosted finishes.

Nine shades of nail polish and six toning lipsticks (both $1.19) are featured in a counter top display unit. Nail polish colours range from an iridescent caramel through all shades of chocolate to a new pinky silver. Lipsticks range from tawny browns to glossy coppers and deepest damson.

Collection 2000 has also launched a cosmetics gift set ($4.99) for Christmas.

It contains lip and nail colour, mascara and complexion powder, and is available in three different colourways: pinks, rose and pearl.

Collection 2000 Ltd.
Tel: 01695 50078.

One market includes 4 out of 10 men.

Life Slice bites into health

Life Slice is a new health food supplement from Lifezyme International Food Enterprises.

Life Slice is formulated to help contribute towards a healthy eating programme. It contains no preservatives, colourings, additives or toxins. It can be a meal substitute when slimming, an energy boost or energy replacement before and after sport, a dietary supplement and a provider of high energy for vegetarians.

Its ingredients include wholemeal self-raising flour, vegetable margarine, oats, medium oatmeal, dried skimmed milk, sesame seeds, honey, unrefined molasses sugar, pure malt extract, black molasses liquid, glycerol BP, K-Syme 7 culture live enzyme, sea salt, boiled water and lecithin.

Life Slice (212-238 calories per 60g bar, $0.99) is available in four flavours: orange, lemon and flaked almonds; mint-coated apple and sultana; banana and walnut; and fruit and nut with apricot. Life Slice has a shelf life of at least 18 months.

Lifezyme International Food Enterprises. Tel: 01554 749275.

Rimmel sets its sights on the Christmas gift market

Rimmel is offering an oval vanity-style satin beauty case containing five of its top-selling cosmetics for the all-inclusive price of $6.99.

The case contains a mascara, an eyeliner pencil, an eyeshadow, a lipstick and a lip pencil.

Targeting the Christmas gift market, the cosmetics alone have a retail value of over $9, says Rimmel.

The case will be available through independent pharmacies nationwide for a limited period from November 18.

Rimmel is also launching the Pandora Collection of face powders, blushers, eyeshadows and lip glosses, all packaged in coloured tins. They are intended as Christmas gifts or stocking fillers.

There are three shades of face powder ($1.99) and blusher ($1.99), and six varieties of eyeshadow ($1.49) and lip gloss ($1.49).

Rimmel International Ltd. Tel: 01233 625076.

Special seasonal big brand cuts

Network Management is offering special deals on its Innoxa, Bionsen, Leichner, Cachet and Noir brands until Christmas.

Innoxa Deep Cleansing Mask and Vital Foaming Wash Gel, Gentle Facial Scrub and One & All Hand Cream will be £1.99 each.

Bionsen, the Japanese Spa Mineral range, has a special offer on its bath, shower, body and hair products, with £1 off normal prices.

With its teenage cosmetic brand, Leichner, Network Management is giving consumers a free mascara (£3.95) with every one purchased.

Cachet deodorant spray and talc are offered together at £1.99 (rrp £2.95 and £3.25 respectively).

Les Essentiels grooming range from Noir, the male fragrance and toiletries range, is marked down from £4.95 to £2.95.

Network Management Ltd. Tel: 01252 351100.

Say 'aloha' to new health supplement

Hawaiian Pacifica Spirulina is a new organic wholefood supplement from Naturopathic Health and Beauty.

It contains a super-strain of spirulina, a rich microscopic blue/green algae commonly used as a source of energy and for its nutritional properties. The company claims the product can help to promote clearer skin, thicker, glossier hair, stronger nails and help you lose weight.

Suitable for everyone, including vegetarians and vegans, it is available in crystal flakes, which can be sprinkled over food and drinks; as a powder (which can be shaken in fruit or vegetable juice); or tablets. Initial recommended dosage is 3g daily. Prices start at $6.35 for 20g crystal flakes; $9.95 for 100 tablets; and $14.25 for 90g powder.

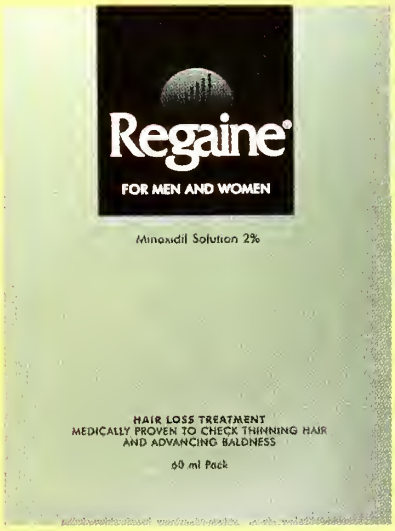
Naturopathic Health & Beauty Co. Tel: 0181 987 8640.

One product now attracts all of them.

Hair loss is just as hereditary as brown eyes and almost as common. Statistically 4 out of 10 men will eventually grow bald. Similarly 1 out of 10 women will inherit thinning hair.

Regaine is the **only** medically proven pharmaceutical product that checks hair loss. Used as medical treatment for over seven years, Regaine has been proved to successfully check hair loss for 4 out of 5 men. And 3 out of 5 women.

This month Regaine is being relaunched in a new improved unisex pack, supported by a £2 million autumn consumer T.V. campaign. Make sure you do not miss out on this opportunity. Contact your Pharmacia & Upjohn representative for more information or ring the Pharmacia & Upjohn telesales team on **0800 801 454**.



Break a family tradition. Keep your hair.

PRESENTATION: CLEAR, COLOURLESS TO LIGHT YELLOW LIQUID FOR TOPICAL APPLICATION, CONTAINING MINOXIDIL 20 MG/ML. **USES:** TREATMENT OF ALOPECIA ANDROGENETICA SLOWING OF HAIR LOSS IN PATIENTS WITH DIAGNOSED MALE PATTERN BALDNESS. **DOSAGE AND ADMINISTRATION:** APPLY 1ML REGAINE TOPICAL SOLUTION TWICE DAILY TO THE CENTRE OF AFFECTED AREA OF THE SCALP. THE TOTAL DAILY DOSE SHOULD NOT EXCEED 2ML. THE METHOD OF APPLICATION VARIES ACCORDING TO THE DISPOSABLE APPLICATOR USED. IN ALL CASES THE HAIR AND SCALP SHOULD BE THOROUGHLY DRY, AND THE SOLUTION ALLOWED TO DRY WITHOUT THE USE OF A HAIR DRYER. TWICE DAILY APPLICATION FOR FOUR MONTHS OR MORE MAY BE REQUIRED BEFORE EVIDENCE OF HAIR GROWTH STIMULATION CAN BE EXPECTED. ONSET AND DEGREE MAY BE VARIABLE. RELAPSE TO PRE TREATMENT APPEARANCE FOLLOWING DISCONTINUATION OF MEDICATION HAS BEEN ANECDOTALLY REPORTED TO OCCUR WITHIN 3-4 MONTHS. PATIENTS SHOULD DISCONTINUE TREATMENT IF THERE IS NO IMPROVEMENT AFTER ONE YEAR. **CONTRA-INDICATIONS, WARNINGS ETC. CONTRA-INDICATIONS:** HYPERSENSITIVITY TO ANY OF THE COMPONENTS OF THE PREPARATION. **WARNINGS:** REGAINE IS FOR EXTERNAL USE ONLY. USE ONLY AS DIRECTED. DO NOT APPLY TO THE AREAS OF THE BODY OTHER THAN THE SCALP. USE OF REGAINE RESULTS IN SLIGHT ABSORPTION (AN AVERAGE OF 1.4% OF THE APPLIED TOPICAL DOSE) OF MINOXIDIL FROM THE SKIN AND THE POTENTIAL FOR SYSTEMIC EFFECTS SHOULD BE CONSIDERED. THE MOST FREQUENTLY REPORTED ADVERSE AFFECTS HAVE BEEN MINOR DERMATOLOGICAL REACTIONS. **PRECAUTIONS:** PATIENTS WITH HYPERTENSION SHOULD BE MONITORED CLOSELY WHEN TREATED WITH REGAINE. REGAINE CONTAINS AN ALCOHOLIC BASE WHICH WILL CAUSE BURNING AND IRRITATION TO THE EYE. SAFETY AND EFFECTIVENESS OF REGAINE IN PATIENTS UNDER 18 OR OVER 65 HAS NOT BEEN ESTABLISHED. AS FOR OTHER PREPARATIONS, CONCOMITANT DAMAGE OF THE SKIN MAY LEAD TO INCREASED ABSORPTION OF MINOXIDIL. REGAINE SHOULD NOT BE USED DURING PREGNANCY OR LACTATION. REGAINE SHOULD NOT BE USED IN CONJUNCTION WITH OTHER TOPICAL AGENTS. **LEGAL CATEGORY: P PACKAGE QUANTITIES:** BOTTLES OF 60ML WITH ONE OR MORE OF THE FOLLOWING DISPOSABLE APPLICATORS: PUMP SPRAY, EXTENDED TIP, OR RUB ON ASSEMBLIES. **PRODUCT LICENCE NUMBER:** PL0032/0136. **HOLDER OF PRODUCT LICENCE:** PHARMACIA AND UPJOHN LIMITED, DAVY AVENUE, MILTON KEYNES, MK5 8PH, UK. **DATE OF PREPERATION:** JULY 1996. **PRICING INFORMATION:** £24.95 RETAIL PRICE (£21.28 EXCLUDING VAT).

Press blitz for Colgate Total

Colgate-Palmolive is backing its Colgate Total and Colgate Total Fresh Stripe toothpaste with a new advertising campaign.

The series, which runs to the end of the month, features colour ads running across the bottom of the news pages in eight daily newspapers and six Sunday titles.

The campaign is expected to have more than 40 hits and is part of a £14 million spend behind the brand this year. Since its launch in April, Colgate Total Fresh Stripe has achieved a 4.6 per cent share of the toothpaste market, pushing the brand share for both toothpastes to 15.2 per cent (Infoscan, August 11, 1996).

Colgate-Palmolive Ltd. Tel: 01483 302222.

Agfa's film double whammy

Agfa is launching two film promotions designed to increase pre-Christmas sales with a combination of attractive packaging and value for money prices.

The company has produced seasonal POS material to increase the impact, including a window frieze, a mobile and dump bin display.

Agfa is offering retailers 50 free Lupe x 8 magnifying glasses with every 50 rolls of CTX or RSX film intended as a customer giveaway.

Consumers can also buy a twin-pack of Agfa HDC 200 film for £4.99 for 24+3 exposures and £5.99 for 36 exposures.

Agfa-Gevaert Ltd. Tel: 0181 560 2131.

Oh so soft and squeaky

Kiddiwinks' new range of soft and squeaky toys has been designed for new-born babies and tiny tots.

Toby Turtle, Katy Crab and Larry Lobster (£2.95) come in primary colours to attract a baby's attention.

Also available is a squeaky Mother Duck and her babies (£2.49).

Call the Kiddiwinks Care Centre on 0800 614688 for products.

Lewis Woolf Griptight Ltd. Tel: 01386 553386.

Wilkinson Sword goes on tour

Wilkinson Sword is targeting its Extra II razor at students this autumn as the sponsor of the Mike Fab-Gere smoothest shave concert tour.

All students attending the spoof Seventies' band's events will receive free packs of Extra II razors and a £0.30 money-off coupon.

Wilkinson Sword Ltd. Tel: 01670 713421.

Medised's message to mothers

Seton Healthcare is continuing to promote Medised in mother and baby magazines until February.

The titles being used include *Practical Parenting, Our Baby, Essentials, Good Housekeeping* and *She*.

The message focuses on the dual action formula, which is paracetamol to relieve fevers and pain, and promethazine for drying runny noses and easing irritation.

Seton Healthcare Group plc. Tel: 0161 654 3000.

ON TV NEXT WEEK

Brylcreem: BSkyB, MTV

Ibuleve: CAR

Imodium: All areas except CTV and GMTV

Movelat Relief: B, G, Y, C, A, HTV, W, M, LWT, TT, C4

Nicorette: G, Y, C, A, M, LWT, CAR, TT, C4

Nutralia: All areas

Oil of Ulay: All areas

Otex: CAR

Pantene: All areas except GMTV

Rimmel: All areas except U

Synergie: All areas

The Wrigley Company/Sugar Free Brands: All areas

GTV Grampian, **B** Border, **BSkyB** British Sky Broadcasting, **C** Central, **CTV** Channel Islands, **LWT** London Weekend, **C4** Channel 4, **U** Ulster, **G** Granada, **A** Anglia, **CAR** Carlton, GMTV Breakfast Television, **STV** Scotland (central), **Y** Yorkshire, **HTV** Wales & West, **M** Meridian, **MTV** Music TV, **TT** Tyne Tees, **W** Westcountry

“They produced an individual planogram for all my shops (It saved me a lot of time!)”

“It made me realise my premises wasn't secure from burglary”

“The efforts of their independent merchandiser have paid off. My sales and customers have greatly increased”

“With one phone call they planned my entire holiday and gave me a 10% discount”

Thank you

COUNTERTALK

YOUR PROFITABLE PARTNER IN BUSINESS

Countertalk is a unique membership only service that is free to pharmacists and pharmacy assistants.

If you would like to join call us *NOW* on the number below or ask your Panpharma representative.

01494 766866

panpharma

Panpharma Limited, Repton Place, Amersham

Presentation [illegible]

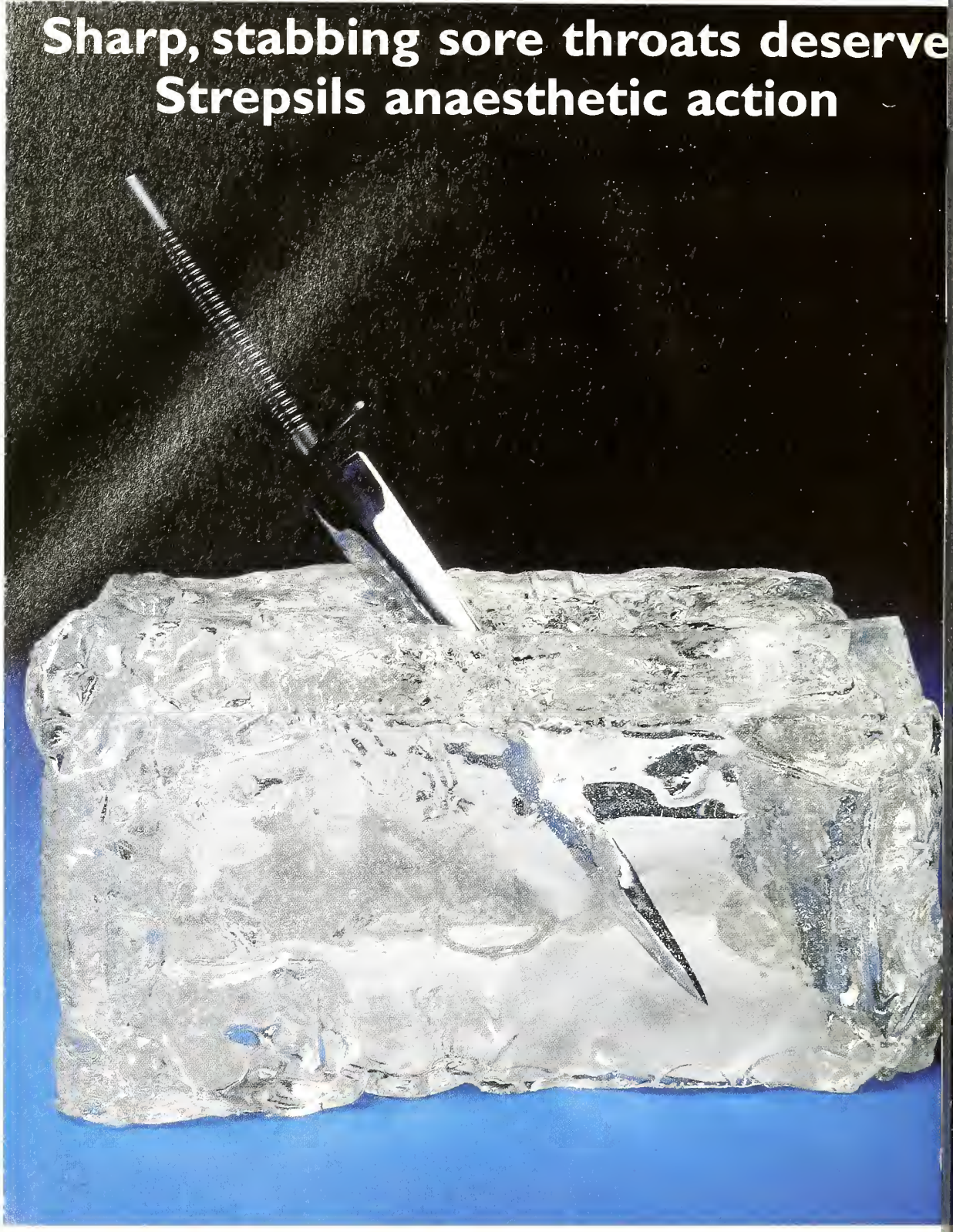
Also [illegible]

Indications: [illegible] relief of [illegible] Dosage & Administration: Adults and children over 12 years: One lozenge to be sucked every [illegible] as required. No more than 6 lozenges to be taken in any 24 hour period. Contra-indications: Not recommended for children under 12 years of age. Precautions: If pregnant or breast feeding, consult your doctor before using this product. If you are allergic to any of the ingredients listed, do not use this product. Consult your doctor if symptoms persist or are accompanied by [illegible] fever or headache. Side effects: May occasionally cause allergic reactions. Packaging Quantities: 24 lozenges in a carton. Legal category: [P] RSP: £2.15 PL 0327/0078. Product Licence Holder & Manufacturer: Crookes Healthcare Ltd, Nottingham NG2 3AA. Prepared September 1996.

Presentation: Red liquid containing Lidocaine Hydrochloride Ph. Eur. (lignocaine) 2.6mg per spray. Also contains: Purified water, sorbitol solution, flavourings, (levomenthol peppermint, aniseed), sodium citrate, saccharin, alcohol, carmoisine edicol (E122). Indications: Symptomatic relief of severe sore throats. Dosage & Administration: Adults and children over 12 years: Aim nozzle at back of throat and spray three times; this is one dose. Repeat every three hours as required. No more than six doses in any 24 hour period. Contra-indications: If you are allergic to any of the ingredients listed do not use this product. Patients suffering from asthma or bronchospasm. Not recommended for children under 12 years. Do not inhale whilst spraying and avoid contact with the eyes. Precautions: If symptoms persist or new symptoms arise (fever, headache, nausea and vomiting) talk to your pharmacist or doctor. If pregnant or breast feeding, or taking any other medication, consult your doctor before using this product. Side effects: May occasionally cause allergic reactions. Patients may experience numbness of the tongue and therefore care may need to be taken in eating and drinking hot foods. Packaging Quantities: [illegible] bottle. Legal category: [illegible] RSP: £3.99 PL 0327/0089. Product Licence Holder & Manufacturer: Crookes Healthcare Ltd, Nottingham NG2 3AA. Strepsils is a Trademark. Prepared September 1996.

CROOKES HEALTHCARE

Sharp, stabbing sore throats deserve Strepsils anaesthetic action



NEW

Strepsils DIRECT ACTION SPRAY

(Contains Lidocaine Hydrochloride)

Anaesthetic to numb pain. Medicine for severe sore throats.

20ml. About 50 Doses

24 LOZENGES

DUAL ACTION Strepsils®

ANAESTHETIC FOR RAPID PAIN RELIEF
2 ANTIBACTERIALS TO TREAT INFECTION
MEDICINE FOR SEVERE SORE THROATS

Contains lidocaine hydrochloride

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With the trusted Strepsils name now with anaesthetic, both products make an effective recommendation.

RECOMMEND THE ANAESTHETIC WITH THE NAME THEY TRUST

The flood that leads to fortune ...

"Community pharmacy is at that time of flood that leads on to fortune."

National Association of Co-operative Executive Pharmacists' president Geoff Flint paraphrased Shakespeare as he welcomed delegates to the 47th annual conference held in Preston, Lancs, last weekend.

He suggested that community pharmacists have to focus on four key areas: the physical appearance of premises, how pharmacy can better be represented within the premises, how staff are deployed and trained, and to ensure that pharmacy is keeping up with other service providers, whether it be a professional health service or a retail service.

"As we journey into the New Age, let us remember that every period of change is a period of opportunity," he said.

The Millennium beckons for NACEP president Geoff Flint

A step nearer to settlement?

Is the remuneration deadlock set to be resolved with the Department of Health re-opening communications with the Pharmaceutical Services Negotiating Committee? This was a possibility put forward by PSNC secretary Stephen Axon.

A letter was received by the PSNC two days after Mr Axon had told NACEP delegates that he expected it to address two areas – the global sum and "hopefully the advance payments situation".

"The letter will show us one thing – we have had the 'Listening process', we have had two meetings where the Government has listened to us, but what we will find out is whether the Government has heard us," he said.

He thought PSNC had been successful in the area of local devolution. Although the Government had wanted to see 20 per cent of remuneration devolved to a local level, he said there is currently a very small amount devolved – the vast majority has still not been devolved.

But he did say there was a degree of unfairness "as some areas were negotiating larger fees than in other areas. Those that overspend impinge on the global sum". "Some LPCs argue that it is up to them to get as much money as they can for their contractors. PSNC's advice is to work as far as possible to your budget, not within the budget, because that is the fairest way possible where contractors are concerned."

The allocation of monies within the health authorities caused more concern. He explained that there are two 'pots' of money:

- Part II money is basically the global sum set aside for those pharmacy contractors providing services that are listed.
- Part I money "is a general pot, which is available for everyone to dip into, provided they can make a good case for providing a service".

PSNC secretary Stephen Axon

Out of hours services were a case in point. Mr Axon was aware of several GP co-operatives which were asking pharmacists "to provide rotas to service those co-operatives with what is essentially an emergency service. This is not the reason why that money is provided.

"If the health authority wants that kind of service, there is nothing to prevent it from providing additional money from the Part I budget for these additional services."

Mr Axon encouraged local pharmaceutical committees or pharmacists to put in bids for that money. "The money is there. It is a matter of priorities. If the health authority is not prepared to give pharmacy the appropriate priority, then, clearly, they cannot expect to receive the service."

On the matter of oxygen devolution, he said that to some extent, it has always been devolved. He questioned whether negotiations were on a local, regional or national basis.

"We have to look at how much control is being exerted on health authorities from regions, because if it is control from regions, it is certainly something we need to react to."

The strategic approach of PSNC is concerned with the contractor pharmacist. "The main thrust is to make the community pharmacy be seen as the area where patients drug therapy is managed," he said.

"PSNC has to look at how that fits into the remuneration structure or how the remuneration structure should be changed – should it, for example, be a core service or a 'bolt-on extra'?"

> **Pharmacy in a New Age: clinically orientated, professionally satisfying but free from commercial considerations**

PSNC has given money to allow LPCs to better represent themselves in negotiating locally. Mr Axon suggested that "LPCs should be looking among their personnel for those people who are best skilled to negotiate on their behalf, and to hone those skills".

Turning to 'Pharmacy in a New Age', Mr Axon said he was surprised at how little correspondence there has been in the pharmaceutical press. The document is clinically orientated, professionally satisfying, he said, "but it is very free from commercial considerations or pressures".

He wanted to raise some questions with the RPSGB. The first was: "How many community pharmacists and pharmacies will be necessary to provide the service in the New Age?" He told the audience to bear in mind the criticism PSNC received over the threshold decision.

To the statement about remuneration in the PIANA document, that it shall "not hinder the use of professional expertise as now", Mr Axon asked: "Is PIANA suggesting that community pharmacists cannot be trusted to use their professional expertise in the best interests of the patient and that they put profit before that of best interests?"

He commented that PSNC was well aware of the inadequacies of the current remuneration system, "or, more particularly, of the perverse incentives it contains. It is also aware pharmacists sell medicines for profit. I don't believe the way round this is to change the structure of remuneration.

"Is the Government's alternative remuneration structure of taking money from the distribution of medicines and giving back in return for cognitive and other services outlined in PIANA in the vision of the future?

"If money is to be diverted away from the supply function and towards cognitive services, how is the high cost of the stocking and distribution of medicines going to be funded in the future?"

PIANA, remuneration and the Society

"There are some tensions around at the moment in the way PSNC and the Society negotiate the future," said Royal Pharmaceutical Society vice president Peter Curphey.

"Tensions arise when we talk about change. We are not intending to fall out with the PSNC." He disagreed with some of the criticisms put forward by PSNC regarding the 'New Age' document. "The consultation process has been about the profession discussing its own future."

He believed remuneration should favour and foster pharmaceutical services, but there were "perverse disincentives". However, he emphasised that, "as a Society, we have no wish to get involved in remuneration, but it reflects the way we practise so we have to take an interest".

Mr Curphey concurred with one PSNC view. "I agree that pharmacy must get its house in order in practice standards before it can move on," he said.

Mr Curphey believed that there must be developments in close working with other health professionals.

"Extreme competition has led to isolation. Competition is something that other professions do not have a problem with. Pharmacy has developed down 12,000 different routes – this cannot be right," he said.

Predicting healthcare in the future, he said: "There will be no primary or secondary care in 2020. It will be seamless care led from the community."

Doctor dispensing he saw as "a tug of war over the right to dispense. It is always argued on professional lines, but essentially it is over remuneration."

Peter Curphey, vice president of the Royal Pharmaceutical Society

He said the arguments were "undignified and unnecessary" and added, " I believe remuneration issues are central to the doctor dispensing issue."

Primary way will continue

The possibility of a new Government does not mean that the direction of the NHS will necessarily change.

This was the opinion of NHS Executive (North West) primary care director Peter Rowe. He explained that "the drivers for change in the NHS are largely outside the control of the Government", a trend seen worldwide.

The release of the Government White Paper this week met with Mr Rowe's approval. "It would be a pity if it did not go through parliament," he said.

He also thought it likely that a new primary care Bill setting out the next 10-15 years of healthcare will be carried. He predicted "a potential review of the Medicines Act" in the first parliament after the election.

"The idea of central contracts is disappearing to a multiplicity of locally-negotiated contracts for populations smaller than the health authority," he said.

This might mean individual pharmacies negotiating. He advised that "pharmacists need to understand what the priorities of the NHS are". These are published each June in the 'Priorities & Planning Guidelines'.

He felt that pharmacists work in a competitive environment, but asked, "How do you join together to form a local partnership?"

He hoped that the new Bill would 'incentivise' pharmacists but warned: "Pharmacy can stand on the outside and watch or get involved. I advise you to get involved – look at how you can change our business."

Peter Rowe: "get involved"

Resale Price Maintenance is a "tough, tough, tough issue to get over to the patient – why should [the consumer] have to pay more for their medicines?", said Michael Baker, head of regulatory affairs at the Proprietary Association of Great Britain. He reported that media coverage had split equally on the "strong emotive" issue, but that "the regard of the public towards the pharmacist has been a valuable resource to the Community Pharmacy Action Group".

Invest in IT now warning

Information Technology can take pharmacy in a new direction, says Simon Driver, deputy managing director of John Richardson Computers.

However, he warned a lack of investment means pharmacy is falling behind other health professionals and other retailers. Up to about three years ago, computer systems in pharmacy were some of the most advanced in the market, but that is not the case today.

"There has been a resentment to reinvest in IT and this means that [pharmacists] have a quantum leap to make," he said. "If you do not invest now, it means there will be higher costs later on."

He warned that pharmacists must get involved. "IT cannot be removed from the profession," he said and recommended that IT must be part of an ongoing business investment programme. "Traditional demands are changing," he said.

Mr Driver was surprised that pharmacists still see their computer's *raison d'être* as being to produce labels. The computer systems "needs to be more patient-orientated", he said. "Labelling should be a by-product. You have got to get more care programmes," he advised.

He also thinks that the computer should be brought out of the dispensary into the shop. This would, for example, demonstrate the relevance or "market" patient medication records to the customer.

Information is the key

There is information in pharmacies that is valuable to the whole medicines supply chain, according to Alan Turner, sales director of AAH. "The flow of data can help us all."

He cited specific micromarketing which targets pharmacies where there is a higher than average number of patients taking certain drugs.

In the US, wholesalers are managing stock inside pharmacies, which frees the pharmacist to go and meet the patient.

'The road to success is paved with information' was a sentiment agreed with by Bryan Edwards, chairman of the Walter James Partnership speaking on behalf of MHG (Systems). "If you do not have good information, then you have no information at all," he said.

The new customers are time-poor but relatively cash-rich, he suggested.

For this reason he recommended using the smart card to collect data about customers' loyalty so that they could be targeted to increase sales.

Keep an eye on Europe

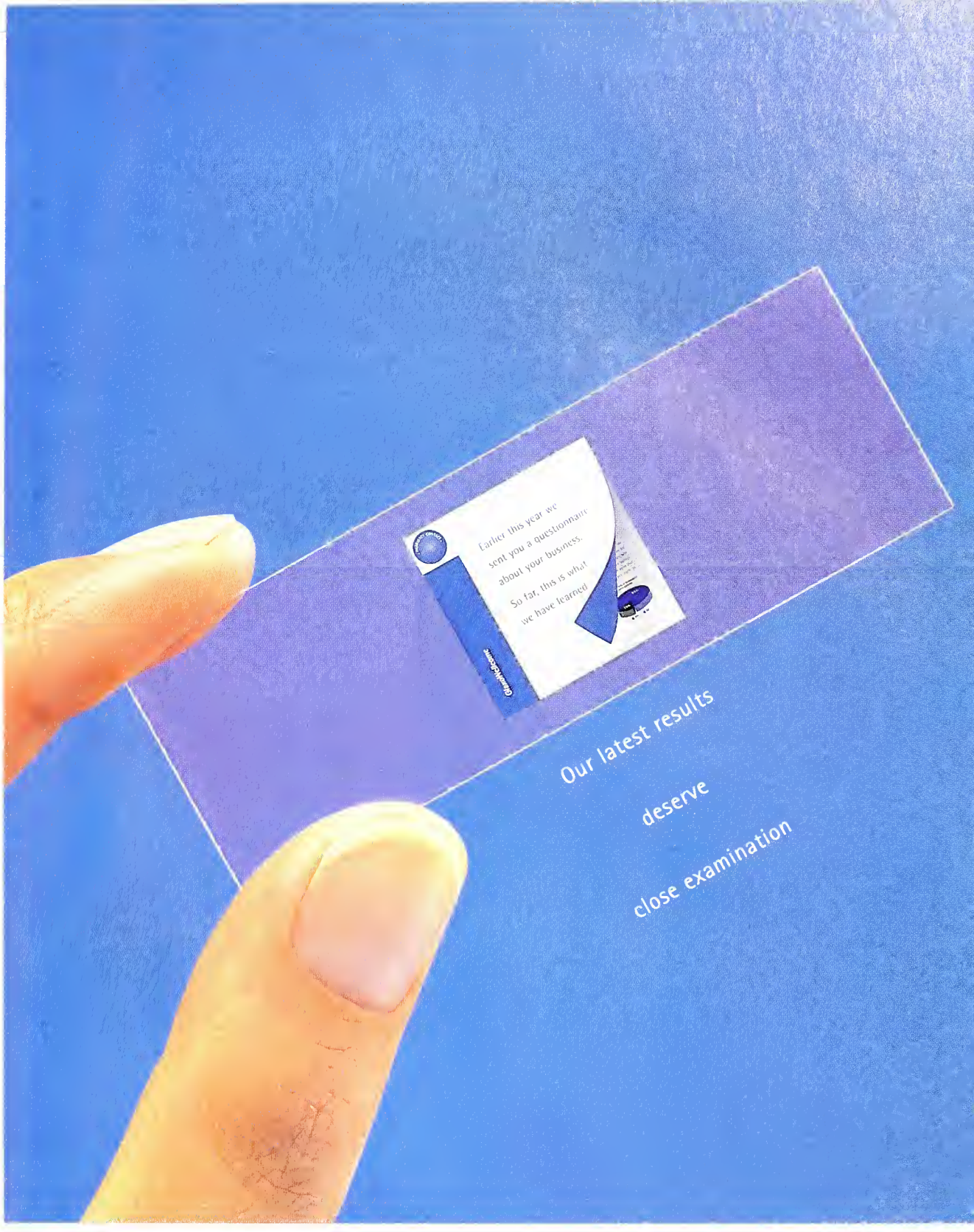
Wally Dove

Pharmacists should keep their finger on the pulse of what is happening in Europe, advised National Pharmaceutical Association Board member Wally Dove.

He was concerned about new legislation coming from Europe that could adversely affect pharmacy.

He cited new legislation that goods will have to be unit priced from June 1. The NPA was fighting this move, he said, because it will have adverse effects on small businesses. "Everyone agrees unit pricing of medicines would be completely meaningless."

On health and safety issues, he said that new legislation on enforcement of standards would carry a criminal code. Unlike in some parts of Europe where many rules are ignored, Mr Dove said that new legislation "adds to the teeth of the health and safety officers in the UK".



We gathered facts, figures, answers and opinions. The overwhelming majority of which were helpful and constructive.

From this wealth of information, gathered by the massive response to our Community Pharmacist Questionnaire, we are building a much better understanding of the issues facing everyone working in community pharmacy. We are now passing this response, distilled into a concise report, back to you. Whatever your views, we hope you find it stimulating reading.

GlaxoWellcome

Treatment guidelines in terminal illness

Palliative care and discharge planning were topics on the agenda when the Hospice Pharmacists Association met in Stratford upon Avon last month

Treatment guidelines that have been drawn up by the Hospice Pharmacists Association are being promoted by the National Council for Hospice and Specialist Palliative Care Services.

"Such guidelines are an excellent tool in improving palliative care for people suffering from terminal illness," says Trevor Jenkins, a principal pharmacist at Stoke Mandeville hospital.

The guidelines should be available soon, but he cautioned that to be effective, all healthcare professionals should know they are there and make use of them.

The advantages to purchasers are that they:

- are evidence-based
- allow flexibility for local agreement
- provide a rationale for unlicensed use of medicines
- give a base for core drug formularies
- are auditable.

These points are important in the light of guidance expected from the Department of Health on continuity of care for people with terminal illnesses, he says.

Treatment guidelines differ from core formularies because they focus on improving care for the patient, whereas core formularies are product-orientated and offer the benefits of rationalisation of drug use, and information.

CD storage

The HPA has contacted the Home Office about the problems faced by hospices in storing Controlled Drugs.

Self-medication programmes have become an important issue. Hospice services have changed and many patients who enter hospices now only do so for a short time for symptom control.

Hospices are technically nursing homes and so the Misuse of Drugs Act Safe Custody regulations apply.

The Home Office is reluctant to say in writing that a patient's CDs may be kept in lockable drawers. However, provided that there are suitable safety procedures approved by the local Home Office inspector, there should be few problems, says Mary Allen.

Most people die at home ...

"Many people think that those with terminal illnesses die in hospices or hospitals," says Helen Wright, pharmacist at St Columba's Hospice and Fairmile Hospice, Edinburgh. In fact, the majority of patients enter hospices for symptom control, especially pain management, and then return home to spend their last weeks or days with their families.

It is important for pharmacists who participate in discharge planning to ensure that effective symptom control gained in the hospice is continued once the patient returns home, she says. This includes monitoring multiple drug therapies, unlicensed formulations, managing wound care and obtaining products for patients.

Through her work, Mrs Wright found that the average community pharmacy deals with 15 patients per week who have been discharged home from another setting, and dispenses for 20 patients with cancer, and four who are terminally ill. Other research has shown that 60 per cent of patients use the services of one chosen pharmacy.

The medicines compliance rate is not good in terminally ill patients – 40 per cent of patients in one study had difficulty in swallowing medicines, 18 per cent forgot to take their medicines at the prescribed times and more than 50 per cent had general difficulties.

Patients may also be taking or using medicines for conditions other than terminal illness, she said, and this could cause confusion.

PHARMACY update

East meets West

Traditional Chinese herbal medicine is finding favour in the West, particularly in areas where orthodox medicine has failed. Dr Brian Whittle, chief scientific officer and co-founder of Phytopharm, looks at the principles and modern applications of this line of medicine, focusing on its success in treating eczema

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 31), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* NOVEMBER 9, PROVIDES 1 HOUR OF CONTINUING EDUCATION

OBJECTIVES

- To appreciate the principles of Chinese herbal medicine
- To be aware of how the theory is applied in practice
- To understand the concept of mode of action
- To appreciate the importance of quality control
- To be aware of Zemaphyte and its application

There is growing interest in complementary therapies, particularly traditional medicines. In some ethnic cultures, the use of natural products as medicines is firmly based in written and oral tradition. For about 80 per cent of the world's population traditional medicines are the only accessible treatment.

In China, the use of vegetable (including herbal) drugs to treat disease was first described in the 'Inner Classic of the Yellow Emperor' (300-100BC). During the past 15-20 years, traditional Chinese herbal medicine practitioners in the UK have had remarkable success in treating eczema and serious skin disease which have been too severe to treat with corticosteroids.

Principles

Chinese herbal medicine is part of a broader branch of medicine, called Traditional Chinese Medicine (TCM), from which shiatsu and acupuncture have evolved.

Diagnosis and treatment is based on different principles from those in the West and diseases are perceived as syndrome complexes, not as single clinical entities. There are references to Chinese philosophy, arts, astronomy, religion and ethical codes, all combined into a unified concept of health and disease.

The end product – the medicine – is effective for use even in serious disease and is now being subjected to the gold standard of controlled clinical trials to establish safety and efficacy.

TCM follows the principles laid out below:

- **Chi and meridians** TCM believes a finite amount of energy, chi, circulates our body through invisible channels called meridians. Chi can be depleted by certain lifestyles and stresses leading to disease.
- **Yin and yang** Disease is perceived as a disharmony in the balance between yin and yang – opposite yet complementary aspects which regulate bodily systems.
- **The five elements** TCM believes the universe is made of the five elements: wood, fire, earth, metal/air and water. These form our dynamic energetic relationships – orbits of function – with the different components of the human body. When well tuned, the orbits of function are associated with good health, but when in disharmony, they lead to disease.
- **Plant medicines** Another characteristic of TCM is the use of various plant-derived medicines, such as flowers, roots and stems. Although Chinese medicines are normally brewed as a tea, other formulations, such as granules, pastes and tablets, also exist.

Application

During a consultation, the practitioner takes a detailed case history, examines the presenting condition and looks at other factors affecting the disease, until a pattern of disharmony is established.

The practitioner then chooses from a range of *materia medica* to construct a prescription. By constructing a bespoke prescription for each patient, TCM practitioners achieve a high level of therapeutic benefit.

TCM appears to be particularly effective in certain

Continued on PII ▶

Continued from P1

conditions and diseases. One example is immune system dysfunction. Orthodox medicine is currently less than satisfactory and often involves the use of corticosteroids and immune suppressants, by default.

Mode of action

The success of TCM makes investigating mode of action a stimulating challenge. For many years, the way in which anaesthesia is produced by acupuncture was unknown but can now be understood in terms of the release of endorphins by stimulation of specific nerve tracts or meridians.

The mode of action of Chinese herbal medicine is based on immunology and pharmacodynamics. 'Complex' prescriptions contain a number of botanical species: some, like liquorice, are known in Western pharmacopoeias, others, like peony, rehmannia (Chinese foxglove) and dittany, are related to ornamental species in the West. Others are exotic species which only grow in South East Asia.

These 'complex' prescriptions contain a hierarchy of component vegetable drugs, which include principal agents as well as additive/synergistic components to reduce toxicity. Attempts to take apart a prescription to identify the active component have so far shown that the total prescription is greater than the sum of the parts.

Establishing mode of action and active substances therefore is not a priority when trying to explain efficacy. Chinese practitioners would claim that in seeking a specific active constituent we are asking the wrong question.

A first priority has been to demonstrate that the medicine works and is safe under the controlled conditions of clinical studies in Western hospitals. The question to ask is what standardised formulas could be used to provide benefit to a majority of patients in a defined therapeutic category, so that the Western disciplines of statistical evaluation of a controlled trial could be brought to bear.

Quality control

For Western standards of quality control to be used it is necessary to look in terms of quality, safety and efficacy.

One way this can be done is by carrying out instrumental tests, such as thin layer chromatography, which gives a characteristic fingerprint. Where the active ingredient is not known, it is possible to provide reassurance on quality by using marker substances.

While the aim of the research is to define a molecule that is responsible for the useful clinical activity, it is also possible to provide instrumental data showing consistency and stability from batch to batch. However, it should be noted that climate, horticultural factors, harvesting, processing and storage conditions may all affect batch consistency.

TCM is based on careful clinical observation. The window of safety of efficacy which has been defined serves to regulate the doses and conditions under which TCMs are used. Unfortunately, this type of evaluation and surveillance is not sufficient to justify the unregulated use of TCM in Western medicine and it is necessary to provide objective data on quality, safety and efficacy.

One pharmaceutical company, Phytopharm, is committed to research into this field and has found that TCM does work in major therapeutic areas and there is a satisfactory risk/benefit ratio. To ensure high standards Phytopharm has devised an instrumental regime of quality control tests which complement the Good Manufacturing Practice standards for the preparation of products.

Zemaphyte

The first product to be studied and trialled by Phytopharm according to Western principles is Zemaphyte (trademark), a standardised formulation of ten herbs which is widely used in Chinese medicinal plants to treat people with severe, steroid-resistant atopic eczema.

Although the majority of cases of eczema are mild and respond satisfactorily to simple topical treatments, in a significant number of cases the disease is more troublesome and, at its worst, may require hospitalisation. This type of eczema is poorly treated with existing therapies and it was decided to carry out clinical studies at Great Ormond Street Hospital for Sick Children, the Royal Free Hospital and the Middlesex Hospital, which are all tertiary referral centres for the most severe type of eczema.

A full-scale placebo-controlled clinical study was undertaken, and clinical studies have subsequently been carried out in other UK hospitals. The first trials[1,2] with Zemaphyte, given either as a decoction or as taste-masked granules of dried decoction, showed a statistically highly-significant and clinically-important decrease in erythema and skin surface damage in groups of the most severely effected patients.

The studies also provided information on safety of the treatment. The incidence of adverse events (mainly transient GI tract disturbance) has been about 15 per cent. The incidence of liver function test abnormalities was around 2 per cent. The adverse events are reversible when treatment is withdrawn and most cases are not considered severe.

The definition of safety is important in establishing the treatment in an area of disease where the alternatives are associated with a high degree of adverse events, or a low ceiling of efficacy. Phytopharm has recently submitted a product licence application for this product to the Medicines Control Agency. Meanwhile, Zemaphyte is available on a named patient basis in granulated form.

Other TCM products

The positive response by clinicians, and the high degree of acceptance by patients, has encouraged Phytopharm to develop additional products based on TCM in skin disease.

Possible modes of action have been explored[3] and the investigative work has taken Phytopharm to the cutting edge of immunological science and investigation at a sub-cellular level. It has shown that Zemaphyte can inhibit the proliferation of low affinity IgE (CD23) receptors in Langerhans cells in the skin. However, the activity of Zemaphyte is limited to eczema with no effect on asthma or hayfever.

In addition to its work in treatments for eczema, Phytopharm is looking at the treatment of psoriasis, and, more broadly, at wound healing, asthma, diabetes, rheumatoid arthritis and Alzheimer's disease. These treatments come from a range of traditional medical cultures.

Box 1: Guidelines on the use of Zemaphyte (as recommended by the National Eczema Society)

- For severe, widespread, atopic eczema, where skin is especially dry and free from infection.
- Taken under direct guidance of a dermatologist.
- Blood and urine tests to be carried out by doctor before treatment, repeated one month, three months and six months after starting Zemaphyte. Thereafter tests should be repeated every six months.
- Zemaphyte is contra-indicated in children under two, in people with eczema other than atopic, in people with jaundice or a history of liver or kidney disease, in pregnant or breastfeeding women.

Qualified sceptics

There is some concern about the use of unstandardised TCM by practitioners who may or may not be adequately trained in their use. Pharmacognosy has disappeared from the pharmacy curriculum, and phytochemistry provides only part of the information required for an understanding of medicines derived from vegetable drugs.

The past 10-20 years has seen an almost exponential increase in the number of traditional medicine practitioners in Western Europe. Some are immigrants, others are being trained here by organisations such as the National Institute of Medicinal Herbalists (Middlesex University), which includes a section on TCM in its curriculum. A more comprehensive course is offered at the School of Chinese Medicine, based in Church Westcote, Oxfordshire. There is renewed interest in some of the schools of pharmacy for this area of research – which is where pharmacy started.

Western medicine, like TCM, is based on careful clinical observation and owes a great debt to TCM. It is fascinating that we now have the tools to explain some of the ways in which these treatments work in serious disease, nearly 3,000 years after they were first used.

References available on request.

C&D is accredited by the College of Pharmacy Practice as a provider of distance learning material until December 31, 1997.

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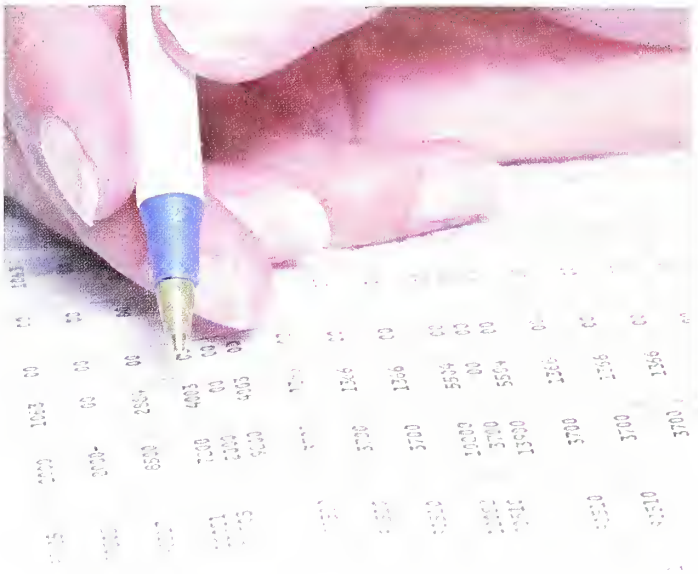
A PACT with authority

At first glance, the PACT (Prescribing Analysis and Cost) report looks like an information systems masterpiece which only a genius can decipher. Not so, say Dr John Ferguson, medical director at the Prescription Pricing Authority, and Martin Jenkins, its deputy director of pharmaceutical advisory services



The Prescription Pricing Authority is a Special Health Authority within the National Health Service in England, which can trace its origins back to 1913. Last year, 487 million prescription items were processed and the number of prescriptions has been rising by 4 per cent per annum. The total cash value is over $4.2 billion per annum, which is about 10 per cent of the total expenditure of the NHS in England.

In 1976, an inquiry into the functions, organisation and constitution of the PPA was requested. This was prompted by delays in paying the accounts of chemist contractors and dispensing doctors, and by difficulties in obtaining information about prescribing patterns. This was urgently needed to tackle the problem of the cost of the pharmaceutical services.

The inquiry identified that the short-term problems of prescription processing could only be overcome in the long-term by computerisation, which would, in turn, provide an information feedback system on prescribing patterns to general practitioners and health authorities.

The dawn of IT

The first computerised information system was based on the manual PD2/PD8 system, which was used by only a small number of practitioners. Experience with this system led to the development of a more informative and selective information system based on PACT.

To ensure that the PACT system met the needs of general practitioners, a user group was set up. The group included members from various health bodies, such as the Department of Health, the PPA, the Royal College of General Practitioners and the Royal Pharmaceutical Society.

It was decided to produce a system which would provide GPs with well presented, timely and frequent information. To ensure that users were not swamped with information, the system was designed to present the information at three different levels, depending on the needs of the GP

PACT implemented

The PACT system was implemented in August, 1988, and every three months around 8,000 GPs received a summary of their prescribing for the previous quarter in the form of an automatic Level I report.

Level II reports highlighted the areas of prescribing where the major costs were incurred. These were 'remedial' in the sense that they were sent automatically to general practitioners whose overall prescribing costs had exceeded a predetermined threshold.

Level III reports were only issued at the request of individual GPs, as they contained a full catalogue of all the prescriptions issued during the quarter and provided a level of detail which was only useful to those interested in self-audit of their prescribing or in the development of formularies or practice protocols.

The Leeds PACT pilot scheme demonstrated that substantial savings in the drug budget can be achieved by generic prescribing, therapeutic substitution and reducing inappropriate prescribing.

Within a year of the introduction of PACT and the receipt by GPs of prescribing details, the PPA showed that the number of high-spending doctors was decreasing, suggesting that feedback works.

Upgraded system

In 1991, the NHS Management Executive called for a more integrated approach to the planning, management and delivery of primary and secondary healthcare, including pharmaceutical services, and stated that the rational effective use of medicines requires pharmacists to work in close collaboration with doctors, nurses and other health and social care professions.

As a result, updated and improved PACT reports are now available and in use. These are high-quality, user-friendly reports which contain more practice-specific prescribing information and additional features, such as a practice's 'Top 20' drugs and the proportion of new drugs prescribed.

These new standard PACT reports replace the previous Level I and II reports, and are

Continued on PVI ▶

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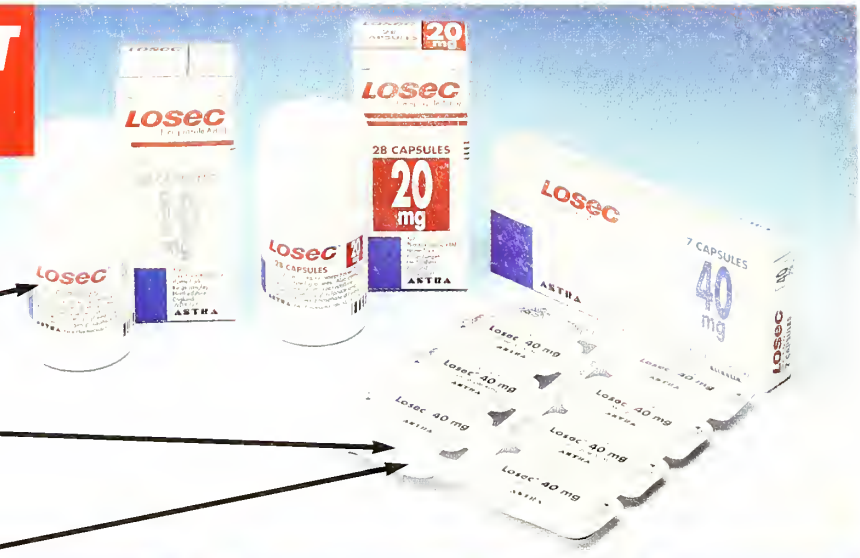

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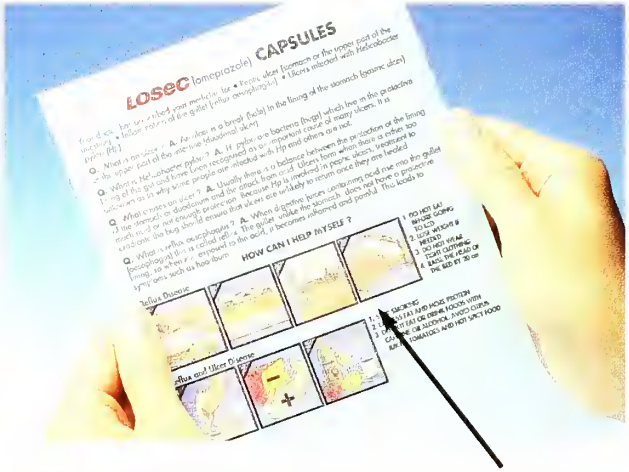

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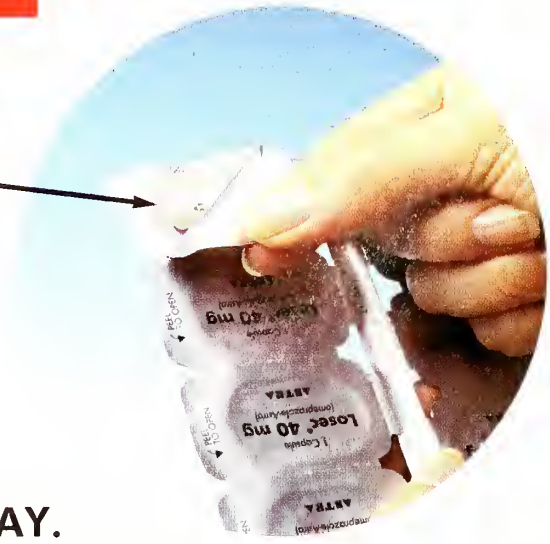

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Continued from PIV

sent to all GPs in England every three months towards the end of August, November, February and May. The previous streaming of reports has been discontinued so that they are now all directly comparable.

The PPA produces around 29,000 individual prescribing reports off its mainframe information computer through a high-speed laser printer in the course of some ten working days.

Breakdown of PACT

The important features of the new PACT reports are highlighted below, along with suggestions as to how the information can be used to monitor prescribing. It would be useful to obtain a sample copy or a copy from the local practice to follow through the discussion points.

● **Practice prescribing costs**

The practice's prescribing costs for the quarter is compared with the HA equivalent (average) and the national equivalent (average) in the form of a simple chart (Box 1). The HA equivalent is based on actual figures for the local HA adjusted to create an imaginary practice with the same make-up of patients and age ranges. The national equivalent is created in the same way.

These equivalents allow practices to see how their prescribing compares with other practices in the HA or nationally. The individual GP's prescribing costs are also shown. Figures are also given to show how these various costs have changes from the previous year.

Discussion points

If the practice's costs are above or below the local or national equivalent, you may need to find out why.

● **Practice costs by therapeutic groups and drugs**

On page two of the report, the practice prescribing costs (and HA equivalents) are broken down into the national top six *BNF* (*British National Formulary*) therapeutic areas (Box 2).

Alongside the costs in each therapeutic area, for the first time, there is a figure giving the percentage of the prescribing costs in each area that are due to new drugs. Drugs are defined as 'new' for three years after their introduction (only new drugs that carry the CSM's black triangle symbol are included).

Also on this page is a list of the 20 leading-cost drugs in the practice giving the number of prescriptions, their total cost, the percentage of the practice total and the change from last year. In addition, brand name drugs in the list are flagged with a 'G' if a generic preparation is available.

Box 1: An example taken from the PACT standard report for the quarter ending March, 1996

Practice prescribing costs		Change from last year (%)
Your practice	£459,746	12
FHSA equivalent	£499,167	8
National equivalent	£478,798	8
Your own costs	£31,518	36

Your practice costs are below the FHSA equivalent by 8 per cent
Your practice costs are below the national equivalent by 4 per cent

Discussion points

1 The top 20 leading-cost drugs highlight individual drugs that are costing the practice a lot of money. Is the prescribing of these drugs appropriate?

2 Where branded products in this list are marked with a 'G', it may be worth finding out how much may be saved by switching to the generic form.

3 Box 2 can indicate therapeutic areas where costs are different from the local equivalent. Are there any reasons for these differences?

● **Number of items prescribed**

Here, an item is equivalent to each order for a product written on an FP10, but the size of an item (amount prescribed) is not considered. For example, a prescription for ten paracetamol tablets is considered as one item, as is a prescription for a 100. A chart shows:

- the number of items prescribed by the practice compared with HA and national equivalents
- the percentage of items written generically
- the percentage actually dispensed generically.

These figures are different because prescriptions may be written generically for products that are not available as a generic preparation and therefore the brand is dispensed.

The number of items prescribed is then broken down into the various therapeutic areas.

Discussion points

1 How does the practice compare to the HA and national equivalent?

2 What is the difference between the generic prescribing percentage and the dispensed generically percentage?

3 Does the practice have a policy on generic prescribing?

● **Average costs per item**

Page four combines the elements of the earlier data to provide details of the average cost per item for the practice compared to the HA and national equivalents. The average costs per item are also shown in each of the therapeutic areas.

The average cost per item will depend largely on the amount prescribed on each prescription and may well reflect practice policy on the length of repeat prescriptions.

● **Practice costs by therapeutic group over last eight quarters**

Line graphs on page five show the changes in practice prescribing costs and HA equivalents over the last eight quarters in the six therapeutic areas. This indicates how prescribing policy changes affect costs and whether the practice spending is converging or diverging from local patterns of prescribing.

● **Top 40 sections of *BNF* in terms of costs**

An extensive table on pages six and seven ranks the practice's own top 40 sections of the *BNF* in terms of cost. The number of items prescribed in each section is given along with comparisons with the HA and the practice's last year figures. Where items, such as dressings, are not covered by a *BNF* classification the PPA has created a pseudo chapter.

This table allows the practice to identify the therapeutic sections that account for the largest proportion of its spending on drugs. These may be sections that the practice wishes to concentrate its attention on through the use of the more detailed information available in the Prescribing Catalogue (*see below*).

Discussion points

1 Is prescribing in the most expensive therapeutic areas rational and evidence-based?

● **Practice details**

Practice details such as list size are carried on the back page together with details of items personally dispensed by the practice. These items are those which attract payment under paragraph 44,5 of the Statement of Fees and Allowances (Red Book). A glossary of terms is also included on this page.

● **Prescribing trends in general practice**

There is an insert in the centre of the standard PACT report concentrating on some important and topical aspects of prescribing in general practice. It is illustrated by national trends in prescribing and looks at the quality issues raised by this aspect of

Box 2: An example of practice costs by *BNF* therapeutic group

	Practice costs FHSA equivalent	Comparison with FHSA (%)	Change from practice	last year (%) FHSA	% new drugs
Gastro-intestinal system	£66,419 £81,361	-18	5	6	11
Cardiovascular system	£63,485 £90,388	-30	7	9	1
Respiratory system	£60,183 £61,034	-1	23	9	10
Central nervous system	£62,743 £60,693	3	18	17	9
Infections	£32,622 £24,514	33	2	3	4
Endocrine system	£34,984 £39,979	-12	17	17	9
All other	£139,310 £141,197	-1	11	5	1

prescribing. There is additional practice-specific prescribing feedback related to the topics featured. A synopsis of the general reports are circulated to all pharmacists in 'PPA Matters'.

Additional reports

Prescribing Catalogues are available only on request and provide details of every item prescribed and dispensed by the practice or individual GP. They can be requested for the practice or partners; specific therapeutic areas; or for a specific time period.

In addition to information provided in the standard PACT, these catalogues detail prescribing rates and set out in detail every item that has been dispensed in the time period, with the quantity prescribed and the cost. The Catalogue also flags products available generically (GFA), new drugs (N), CSM-monitored drugs (CSM) and borderline substances (BS).

This Catalogue is by far the more valuable of the two reports if a practice wants to look in detail at its prescribing patterns and wants to monitor the effects of any changes in prescribing policy.

Limitations of PACT

PACT data are extremely valuable but, as with any statistical information, they have their limitations and potential pitfalls. You need to be aware of these in order to avoid drawing the wrong conclusions and using the data inappropriately.

The population characteristics of an individual practice are unique and can vary enormously from HA and national equivalents. Prescribing in any practice is determined in part by the characteristics of the patient population. When comparing prescribing with local and national averages, these factors, together with the points below, need to be borne in mind, as PACT data does take account of them.

Prescribing units

PACT data recognises that elderly patients generally require more prescriptions than other age groups. Thus for comparative purposes, the patient population is described by prescribing units (PUs). Under this system, patients over 65 account for three PUs on the crude basis that they need on average three times as many prescriptions as under-65s.

The bar charts in the Standard PACT Report compare the practice with a fictional 'average' or equivalent practice. These 'averages' are obtained by dividing the total costs or total number of prescriptions in the HA in that quarter by the total number of PUs in the HA. This gives an average cost or number of prescriptions per PU in the HA.

These figures are then multiplied by the number of PUs in your practice to give the costs and number of prescriptions for a practice of similar size and age profile prescribing at the average rate for the HA.

ASTRO PUs

The Prescribing Research Unit in Leeds has developed a formula – the Age, Sex and Temporary Resident Prescribing Unit (ASTRO PU) – that takes greater account of the differing prescribing needs of males and females in nine different age bands. This new formula allows more accurate comparisons between practices and is already being used to help calculate prescribing budgets.

Practice list size

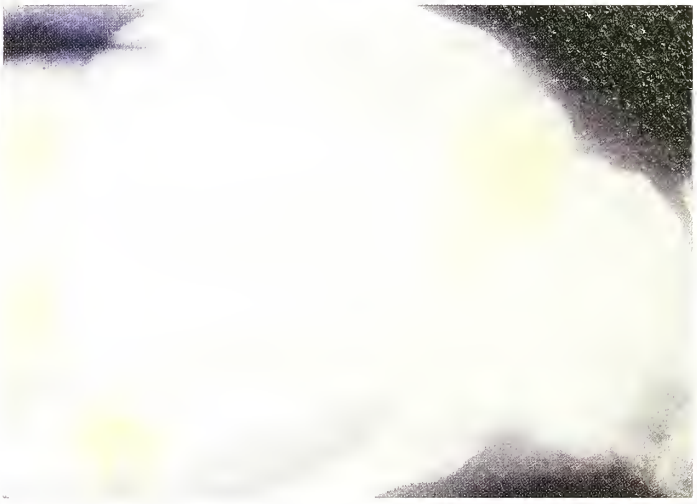
The prescribing and cost rates given in PACT are based on the practice list size held by the HA. While this is fine in areas where the population is stable, prescribing and cost rates may not be accurate where the list size is rapidly changing. Data for individual partners are also based on their personal list size, so unless GPs only see patients registered with them, individual comparisons with practice and other equivalents are of little value.

Cost per item

When looking at cost per item for the practice compared with HA and national averages, it is important to remember that this figure depends on the quantity of drug prescribed each time. A practice that always prescribes repeat prescriptions for three months will have a higher cost per item than a practice that prescribes one month's treatment. Cost per item should be looked at in conjunction with the number of items and quantity prescribed.

PACT data for individual GPs relate to the prescriptions written on that GP's prescription pad or under that doctor's unique prescriber number. Where one doctor's FP10s are used for repeats or nurse-requested items, the PACT data can be distorted. For audit purposes aggregated practice data should be requested.

Written information for arthritis patients



A cheaper way of providing information other than via a telephone service is to provide an educational booklet. However, it is not sufficient just to issue the information – it must reinforce information given verbally, increase patients' knowledge and improve their care. Rheumatologists in Birmingham have shown this is not all achievable with one booklet for patients with chronic arthritis.

Participants were randomised to receive usual care, or usual care plus an educational booklet, 'Living with Arthritis', or usual care, the booklet and a 30-60-minute interview with a health professional. At follow-up after six weeks, all patients given the booklet showed increased knowledge compared with usual care alone but additional input from the health professional had not improved knowledge further. Greater knowledge alone is desirable, but in this study it was not associated with improved care as measured by health assessment questionnaires. Nevertheless, virtually all the patients said they found the booklet useful and 61 per cent wanted more information about the issues it covered.

This study does not prove that written information does not improve health status – in fact, there is some evidence to the contrary – but it does demonstrate that a more informed patient does not necessarily have a better outcome. The role of a health professional, probably an expensive intervention, needs careful evaluation.

*British Journal of Rheumatology 1996;***35***:775-7*

Hazards of ecstasy

Ecstasy – methylene-dioxymethamphetamine – has acquired almost mythical status among users as a 'safe' drug but concern is growing that it has significant toxicity.

The problem in quantifying the risk is that recreational use appears to be widespread, though it is not possible to specify how many users there are, and reports of death and serious adverse effects are highly-publicised but uncommon. Further confounding factors include the unreliable dose and purity of street drugs.

In a recent review of the medical literature on ecstasy, US neurologists note that animal studies have clearly demonstrated that it is neurotoxic. In volunteers, acute adverse effects have included nausea and vomiting, hyper-reflexia, difficulty walking, hypertension and anorexia. Reports from users also include paraesthesiae,

Continued on PVIII ▶

Continued from PVII

hallucinations, motor tics and fainting.

Severe effects include urinary retention, chest pain and seizures associated with hyponatraemia. Psychological effects include anxiety, depression, fear, confusion and paranoia and, experimentally, 30-40 per cent of subjects have difficulty with simple mental tasks.

Fatalities have been associated with cardiac effects, including arrhythmias, asystole and cardiovascular collapse; neurological events, including subarachnoid haemorrhage and cerebral infarction, have also caused death.

Multi-organ failure seems to occur only in people taking ecstasy at raves and in nightclubs, and is associated with hyperthermia, dehydration, rhabdomyolysis, intravascular coagulation and renal failure.

Chronic effects include temporomandibular joint syndrome associated with constantly grinding the jaw; aplastic anaemia and hepatotoxicity have also been reported. Chronic psychiatric effects include flashbacks, panic disorder and aggressive outbursts. Although neurotoxicity in serotoninergic systems has been found in animals, it has not been documented in man but biochemical abnormalities, mood disorder and sleep disturbance are all consistent with such an effect.

This information is alarming, but it is important to remember that anecdotal evidence, though important, is derived from a population who may use other illicit drugs and take substances of uncertain composition; adulteration or contamination may account for some of the problems reported. Further, the absolute risk to users is unknown so it is not clear whether ecstasy is safer than the popular alternatives, which include alcohol.

*Drug Safety 1996;***15***:107-15*

Drug treatment in heart failure

It can be too easy to forget that appropriate drug treatment means the difference between life and death for some people, and not only those with acute life-threatening conditions.

Eight hospitals in Canada participating in a quality assurance programme reviewed the management of 4,606 patients admitted with heart failure during 1992 and 1993. Acute ischaemic events or acute heart failure was the cause of admission in two-thirds of cases, but non-cardiac illnesses accounted for the remainder.

Overall mortality was 19 per cent and was due largely to progression of heart failure. Again, non-cardiac causes were significant, accounting for 30 per cent of deaths. The risk of death increased by more than 50 per cent with those aged over 70.

The most commonly prescribed treatment for heart failure was a diuretic (82 per cent of patients), an ACE inhibitor (53 per cent), nitrates (49 per cent) and digoxin (46 per cent). Although ACE inhibitors (plus a diuretic) are the only treatment shown to prolong life in patients with heart failure, they were prescribed significantly less frequently for elderly patients, in whom mortality was greater, and for women. Although most drugs were associated with a reduced in-hospital mortality, the use of magnesium and nitrates was associated with a greater risk of death.

The authors note two important findings from their study: first, there is a need for new treatments, but existing treatments should be prescribed more effectively; second, non-cardiac illness is a significant cause of death in patients with heart failure.

*Archives of Internal Medicine 1996;***156***:1669-73*

Diabetes control and complications

The Diabetes Control and Complications Trial (DCCT), published in 1993, established that intensive insulin treatment reduces the risk of retinopathy, nephropathy and neuropathy in people with insulin-dependent diabetes.

However, the price of achieving this goal is greater contact between physicians and patients; more insulin injections and blood glucose monitoring; and a much greater risk of hypoglycaemia.

In the clinical trial, the participants were highly-motivated and had a higher IQ than average. There was concern that these obstacles might prove insuperable in practice. No one asked people with diabetes how they felt about the implications of DCCT until diabetologists in Dundee surveyed the views of all patients attending their clinics who use insulin (including those with insulin and non-insulin dependent diabetes).

Questionnaires were distributed with a summary of DCCT and an explanation of its results; 550 – three-quarters of the total – were returned. Sixty per cent of respondents were so impressed by the results of DCCT that they would attempt to improve their blood glucose control. This view was not influenced by a respondent's number of daily injections or blood glucose measurements, or by experience of minor hypoglycaemic episodes.

Younger people and women were more likely to respond positively but, perhaps anticipating the difficulty of tight glucose control and the consequences of severe hypoglycaemia, those with a longer duration of diabetes, a history of more than one hypoglycaemic episode, or with hypoglycaemia unawareness, were less likely to aspire to DCCT standards.

Of respondents who said they would follow the DCCT protocol, 60 per cent said they would attend a clinic more frequently (there were monthly visits in DCCT); two-thirds would pay more attention to their diet; and 77 per cent said they would aim for the necessary blood glucose level of 4-7mmol/l.

Many expressed important concerns about improving blood glucose control. The majority were worried about an increase in the frequency or severity of hypoglycaemic episodes and half were concerned that this might lose them their driving licence. Many – mostly women – also expressed fears that better control would be associated with weight gain; and older patients expressed misgivings about maintaining this for the rest of their lives.

The authors say their findings reveal two obstacles to implementing DCCT: overcoming the concerns of those who are prepared to make the necessary effort to achieve tighter blood glucose control; and persuading those who are not to change their minds.

*Diabetes Care 1996;***19***:76-8*

Research Digest is a regular series, written by drug information specialist Steve Chaplin MRPharmS, looking at current developments in medicine

Hours of burden

'What you get out of a business depends on what you put in it.' Many directors are working much longer hours on the back of that truism. It's working for them. Is it working for community pharmacists? Guy L'Aimable reports

Britain's bosses are working harder than ever, but they are being paid more, too, reports a survey by *Director* magazine. Almost half of them are working more than 60 hours a week, and 5 per cent clock up more than 80. But over half of the respondents say that their financial rewards have improved during the past year.

With many companies cutting costs and slashing jobs, employees at every level appear to be working harder than ever before. Whether they, too, are being paid more as a result is another matter, however.

As the owners and 'bosses' of small businesses, how are community pharmacists faring?

Peter Lowe owns and runs a pharmacy in Sheffield. His work is supplemented by tutoring for the Centre for Pharmacy Postgraduate Education. He also allocates about 100 hours a year as secretary of his local pharmaceutical committee.

> When I talk to my children, they say that, looking back, I wasn't there when they needed me

With all these commitments, Mr Lowe works an average 58 hours a week, rising a few times to 80-85 hours. Sometimes, his workload peters to 40 hours.

Mr Lowe admits his gross rewards have improved over the past few years, but stresses that this is because of the extra work he has taken on. Five years ago, community pharmacy accounted for 27 per cent of his gross profit. Today, the figure is 18-19 per cent.

Pharmacists, he says, receive poor financial rewards because they are paid for the wrong things.

"I'm paid for giving out bits of paper to the Government, saying I've given out drugs. That's all. I'm not paid for talking to patients, giving them advice about how to use their drugs."

The Government's payment system does not give pharmacists any incentives to do more for their patients. "We're paid to give out the cheapest drugs in the quickest time."

Payments aside, the contract that binds community pharmacists prevents them from managing their time more efficiently.

"A pharmacist has to be in his premises 40 hours a week, and he stands there like a spider in a web, waiting for the prescriptions to come in. We must be the only profession without an appointment system," he says.

He says he could work far more efficiently if the contract was amended, allowing him to delegate more of his tasks to his assistants. But he concedes that many pharmacists cannot afford to do this.

"Community pharmacy is becoming less viable. If the Government is not careful, it will end up with very large pharmacies scattered widely, and someone will go round with a van distributing drugs," he says.

Continued on P552 ▶

Continued from P551

Holidays have had to give way to his work. He would normally take three weeks a year, but has taken only one week so far this year. Having to look for and pay a locum is another constraint.

Jayanti Patel laughs when there is mention of holidays. As owner of Hinchem Pharmacy in Leicester, he has not taken one since 1991. "There's always something cropping up and I always think that things will improve next year," he says.

Mr Patel works about 55.5 hours a week, including deliveries. Tougher competition, especially from a nearby out of town shopping centre, has forced him to increase his workload in order to survive.

But the 'rot', as he calls it, set in with the NHS reforms about five years ago. "The NHS's prescriptions are forcing the whole pace of change," he says.

Managing his business has inevitably affected his family life. His teenage son and daughter have not minced their words. "Their reaction is that I'm stupid to work all these hours ... When children are growing up, they expect the whole family to be together. This isn't happening. When I talk to them, they say that, looking back, I wasn't there when they needed me."

Not surprisingly, his children have no ambitions to become pharmacists. "My son says he'd rather take up computing, where he'd earn more money for working fewer hours."

Does his pharmacy at least provide an adequate return? "No, definitely not. When I began as a pharmacist in 1977, you had the cost-plus contract, which compensated you. It's a lot to lose all that, plus managers' compensation," he says.

As NHS prescriptions account for 65-70 per cent of his turnover, Mr Patel would like a pay structure that was linked closely to a pharmacist's NHS business.

He says his quality of life has deteriorated over the past five years. His bank visits have become ritual humiliations. "Every year, we've had to go to the bank and ask them to increase our overdraft to cover the shortfall in the NHS payments. Before, we could manage everything within the limits set by the bank."

Which should the pharmacist choose: less stress and better family life or higher turnover? It is a difficult decision, but Brian Deal has tackled it. "I've cut down [the working hours] because I used to work in excess of 60 hours a week for ten years. And that was just in the pharmacy," he says.

A pharmacist must be in his premises 40 hours a week, and he stands like a spider in a web, waiting for the prescriptions

Ten years ago, when Mr Deal bought Harvans Pharmacy in Walthamstow, north east London, the outlet was trading until 9.00pm every day. Partly to keep the status quo, Mr Deal retained the same hours.

But the extension of supermarket opening hours eroded the shop's appeal. Mr Deal was also swayed by personal priorities. "I've put my family first. I had an additional member to the family and I also decided that, at 35, you cannot do what you were able to do when you were 23."

He is pleased with the results of his lighter workload. "My turnover has gone down at least 10 per cent, but as I began to have some free weekends, my stress has gone down at least 25 per cent."

It is a change – but not good enough. "In relation to what I used to do, it's a big change. But I know other healthcare professionals who have a far better social life because they're working better hours."

Extra care

In contrast, Colin Doorbar – joint partner of H S Dobie in Maryport, Cumbria – says he has worked about 58.5 hours a week for years, and that his hours have not changed much. What has changed, he says, is the difficulty of doing the job. The extra patient care a pharmacist is expected to provide has greatly increased his responsibility. Mr Doorbar says that area needs to be addressed. Computerisation in surgeries has not helped either.

"At one point, doctors wrote the prescriptions. Now we're ringing doctors almost every day to check their prescriptions. Just five minute ago, a man brought in a prescription for one item, but he asked me where were the other items he was supposed to have. We phoned the surgery and found out the items had been left out of the prescription by mistake. That's a common problem and it does involve more work," he says.

Mr Doorbar says he is working harder than ever before, but his rewards are better too, mainly because the pharmacy dispenses about 7,000 prescriptions a month. Mr Doorbar and his wife, a health visitor, annually take about four weeks' holiday.

While the European Union is proposing to introduce legislation to restrict working hours to 48 hours a week, the pharmacists say the legislation is no use to them. Many agree with Mr Patel: "Who's going to pay me for the extra hours I need to work? It's alright for the European Union to introduce these ideas, but are they practical?"

Can anything be done to reduce a pharmacist's working hours? Mr Lowe says it would help if he was paid per patient instead of per transaction, and if the law tying him to his pharmacy for 40 hours was relaxed. "The biggest help would be if pharmacies co-operated instead of competed. Two to three pharmacists could co-operate, which would leave time for one of them to go out [on a rota basis]. We need the same type of system as GPs."

Mr Patel's solution centres on GPs' awkward operating hours. "If they changed their surgery hours to 9.00am-5.00pm, and allowed everyone to come in without appointments, then our lot would improve."

What comes over strongly from this selection of pharmacists is their professional pride and sense of commitment. These factors contribute to the will to work whatever hours are needed, although many admit they have considered selling their pharmacies.

Mr Patel echoes a popular view. "I'm 54 years old, so I could continue for another two to three years to satisfy my professional needs, and to hell with the lower income. But God help the younger pharmacist, who has just started working in a pharmacy."

CHEMIST & DRUGGIST
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Headlice

Seminar No 34

This is one in a series of *Chemist & Druggist* training seminars for pharmacists and their assistants, sponsored jointly with a company having a particular expertise in the title subject

Dr John W Maunder MA, PhD, MSc, FRES, FRSH, director of the Medical Entomology Centre in Cambridge, describes the habits of a headlouse

Profile of a parasite

Not only do parasites have effects on their hosts, they are also profoundly affected by their hosts. Parasitism involves interaction between invader and defender. The physiologies of both become intertwined in complex ways, and this is as true of external parasites as it is of internal ones.

We easily imagine the effects of headlice on people, but forget what human physiological defences are doing to the lice.

When any blood-sucking insect (be it flea, mosquito or louse) bites us, it injects saliva into our skin. The saliva has many components, including a fast-acting anaesthetic substance, which stops the biting process from being noticeable while the insect is still present. (Immediate pain might well bring immediate retaliation!)

Saliva also contains an anticoagulant to prevent the blood from clotting in the insect's feeding tubes and causing a fatal blockage. Naturally, saliva has a range of digestive enzymes, which are also injected into the wound. The proboscis contains two tubes. Down one is pumped saliva and up the second is drawn a mixture of blood plus anticoagulant saliva.

Bite reactions are local allergic responses to this injected insect material. As with other allergies, we cannot react until we have become sensitised. Very young children do not respond to insect bites, which is why flea or mosquito bites are never seen on babies. Sensitisation rarely occurs before four years of age, even with the commoner insects. Before sensitisation, a bite leaves no mark or reaction at all. After, the familiar red, itchy papule follows each bite. If biting continues, the subject eventually becomes desensitised. They then possess a full quota of antibodies against the saliva of that species of insect.

With headlice, children most frequently become sensitised between the ages of four and six. Before then, they may be carrying lice but show no symptoms and are not aware of it – nor are the parents.

Sensitised children develop a bite reaction, rather like a miniature mosquito bite, shortly after each louse feeds. The lice may be numerous and each may feed up to six times a day. The bites come thick and fast, and a general itch of the head develops. However, because the bites are numerous, desensitisation may set in quite quickly. Desensitised ten-year-olds are not uncommon. At desensitisation, all symptoms cease and will never restart. Lice feeding on such people take in antibodies against their own digestive enzymes with every drop of blood they consume. Their digestion becomes poor, their bodies ill-nourished and their rate of reproduction low. This is our immunological defence against them.

Many desensitised adults cannot keep lice at all. Others keep low numbers of unhappy insects which are only too ready to transfer to a better host. These are the dangerous carriers of lice – symptomless, unaware, long-term, adult carriers of small numbers of malnourished insects.

The most significant carriers are obviously adults in the general community. These are the people who keep the problem going. This is why no amount of child or school-

orientated activity has much effect, or ever has had. If the carriers are not found, there will be a continuous never-ending flood of cases, no matter what else is done.

The epidemiology of headlouse infections resembles that of typhoid. Both are diseases kept running by cryptic unaware carriers and only the secondary cases are obvious. The numbers of apparent typhoid cases depends little on the degree of transmission between the secondary cases. Levels are more dependent on the number of symptomless unaware carriers and how their social contacts allow the disease to affect the surrounding community. Treatment of secondary cases can never end an outbreak.

As with typhoid, so with headlice. The numbers of cases in children (secondary cases) depend less on the amount of transmission between them than on the numbers of unaware carriers in the general community and the ways in which their social contact allow them to infect their surrounding population. Treatment of secondary cases alone can never end a louse outbreak and never has.

Nearly all infections are caught through head to head contacts. Normally a rather prolonged, steady contact is needed, which means that the insects are usually caught from someone who is in an affectionate relationship with the recipient. This gives families a chance of discovering the carrier responsible for their problem.

Families should write down the names of everyone the patient could have had a two-minute, steady, head to head contact with during the past month. They should include everyone, no matter how unlikely, for carriers usually are unlikely.

Most people make few such contacts. The list will be short, but, if accurate, on it will be someone who has lice but does not know it. The family should ask everyone on the list to check for lice using a detection comb, 'just in case'. Often the carrier will not be found, but if the attempt is made, sometimes one will be discovered. Then real progress has been made at last.

Staying ahead

Elaine Bartlett, principal pharmacist in community health at the University Hospital Birmingham NHS Trust, gives the health authority perspective

Since April 1, new health authorities have been formed by amalgamating family health services authorities and district health authorities. These are now responsible for purchasing primary, secondary and community services to meet healthcare needs in their area.

It is now the role of each new health authority to formulate and disseminate a policy for the treatment of headlice in its area.

Current informed opinion recommends that such policies are rotational in nature. The aim is to prevent the development of resistance which occurs when insects are continually exposed to any insecticide. This is achieved by using each selected insecticide for a period of three years. GPs are advised to prescribe, and pharmacists to stock and sell, only that product.

Community pharmacists must be informed of proposed changes to the rotation policy

A suitable case for treatment

Michael E Fagan BPharm, MRPharmS, MIMgt, a community pharmacist and postgraduate tutor, discusses the options available for eradicating headlice

Accepting that the pharmacist is satisfied that live lice are present on the patient, the first question to be considered is whether insecticidal treatment is appropriate in the presented conditions. Excluded from product licences are young infants and pregnant women. It is prudent, too, to exclude those with a compromised auto-immune system.

It is also worth considering whether the patient can undertake removal of live lice and eggs by a grooming method. Although such a method will work, not many patients will have the discipline to keep to the strict procedures (compliance with so-called single treatment methods seem to create problems).

The formulation of the insecticides is important in the decision on 'how to treat'. The pharmacist might have to consider lotion, shampoo or cream rinse. Happily, the decisions are getting easier; all shampoos have now been, or will be, discontinued – the manufacturers have recognised that it is less than sensible applying a full-strength lousicidal formulation only to have it immediately diluted with gallons of water!

Now the choices are between an alcoholic or water-based lotion or a cream tinse with properties similar to a hair conditioner. Alcoholic products have the advantage of being quick-drying and pleasant to look at. It is unlikely that the base has any positive effect in treatment, as lice would not become dried out after such a short contact time, but the mobility of these products might help reach parts that other products may not. Such formulations are not suitable for patients who have excoriated skins, have eczema or have asthma or other bronchial obstruction. The isopropyl alcohol is very drying and has a pungent smell.

The aqueous base lotions obviously take a while to dry, but are cosmetically acceptable to most people. Both forms of lotion allow the necessary concentration of lousicide to be in contact with the cuticle of the louse when dry. The properties of the cream rinse formulation are such as to make the patient comply with the method of use without difficulty (like a traditional hair conditioner). This particular presentation has the disadvantage of being the most expensive.

The choice of insecticide has also become easier for the phatmacist. Carbaryl is POM, and Lindane has, for commercial reasons, disappeared from the shelves.

The choice is now between malathion and the two synthetic pyrethroid chemicals: d-phenothrin and permethrin. It is probably true to say that, if each was used in an identical way, there would be negligible difference between them. However, commercial requirements necessitate 'unique selling points' (usps) and so variations in use follow. It must also be recognised that the general public do what they think is correct sometimes without reference to printed instructions.

The longest residual activities belong to malathion and permethrin, which in some circumstances has advantages where re-infection or freshly-hatched lice may occur. However, it must be remembered that residual activity is a decline in activity

well in advance so that they are not left with unwanted formulations. Difficulties can arise when a pharmacy is situated near district boundaries and when a particular product is demanded.

The spread of resistance also depends on the proper use of insecticides and this is where education and counselling by the pharmacist are essential.

Seek the source

Contrary to popular belief, the source of headlice problems lies in the community and not in schools. In the past, school nurses carried out routine inspection of children's heads. This was based on the misconception that schools were the main sources of infestation and that heavily-infested children could easily be identified by head inspections and then treated. This practice helped to perpetuate the 'dirty heads' stigma.

Routine head inspections in schools are ineffective and are no longer undertaken. A quick inspection may identify very 'lousy' children, but will not reveal those with just a few lice. Children who have been checked assume that they are free of infection and they and their parents may not bother to carry out preventative measures.

Carriers are often adults who have been desensitised to lice and are unaware of their presence as they have few symptoms. Action in schools alone is ineffective, but headlice have been eradicated from whole communities by community-based education and proper treatment and contact tracing.

Professional help

Health authority pharmaceutical advisers and community services pharmacists (CSPs) are usually involved in the formulation of local policies and must provide guidelines, education and training so that consistent advice is available. Carbaryl is now the only insecticide which is not affected by resistance problems and GPs must understand the importance of its conservation.

School nurses have a key role in educating teachers, children and parents, and ensuring effective contact tracing. Health visitors and district nurses have a prime educational function in the family situation. It is important that, in the community, all healthcare professionals are aware of the local policy and work together to provide consistent advice about prevention, detection, transmission and treatment.

In the pharmacy

Since the withdrawal of Crown Immunity in 1991, most community health trusts no longer issue free lotions to the public. These are now supplied from community pharmacies on prescription or by direct sale. Increasingly, the pharmacy is the source of information, advice and treatment.

The private counselling area in the pharmacy is the ideal place for the pharmacist or assistant to advise the patient on the proper use of the insecticide and the prevention and detection of lice. The importance of contact tracing must also be stressed.

It is essential that accurate information replaces 'old wives' tales' and the stigma still attached to infection is removed.

The future

It seems unlikely that we will have any new insecticides in the near future, so we must maintain the efficacy of the ones we have. Many health authorities have excellent policies and guidelines, but they are not widely communicated or reinforced. The formation of the new health authorities should make it easier to produce integrated policies that are widely disseminated and followed.

It is estimated that annually in the UK approximately three million children are treated for headlice, but only 50-60,000 new cases are reported, indicating the extent of inappropriate use of insecticides.

I believe that the withdrawal of insecticidal shampoos from the market would greatly improve the current situation, where much unnecessary prophylactic 'ritual' hair washing occurs through a basic lack of understanding of the problem.

Pharmacists and their assistants have a key role to play in educating patients to use insecticides appropriately – so that we always remain one step ahead of the head louse.

and may be a source of worry when the problem of resistance is considered (contact with sub-lethal doses of chemical).

Lindane, although considered a fairly toxic substance, is still used widely in the Western world to treat lice infections, and there appears to be no withdrawal of licence for its use. Sadly for the manufacturer of the product, it could not find a commercial supplier to continue the production of its well known product, and therefore Quellada became Quellada-M.

There is little logic in making lice treatments Prescription only. All of us in the community environment know that the average GP does not attempt to diagnose louse infection and that a lot of treatment is purely to keep the family happy.

In the pharmacy, despite all the commercial incentives, active infection is confirmed before a sale is made. The ratio of sales to NHS (ie 'free') is near enough 50:50; I have my own opinion where most of the waste and unnecessary supply is sourced.

One other bone of contention is the so-called rotational policies of health authorities; there are few retail pharmacists who think it is working – partly through professionals not being aware of the scheme or deliberate breaking of the policy when the patient says treatment has failed. There is also the cross-boundary situation when different siblings or neighbours attend different schools in different authorities!

It is also impossible to create a scientific basis for rotation with three classes of products when one is Prescription only. The answer is for each 'provider', GP, pharmacist, nurse, etc to adopt their own mosaic system – in other words, to constantly change the provided insecticide in a systematic fashion.

Finally, insecticides must not be used for preventing infection. One community nurse I came across used to treat herself every two weeks with an insecticide during the months of September and October as she 'knew' she would catch headlice.

The easiest method of prevention is good daily grooming, combing damp hair with a proper detection comb – not a dust comb and not a nit removal comb. This will keep a head free of live lice.

If, however, chemicals are required, then there is a specific repellent available which works by causing the louse to become confused in its temperature-seeking system. Also bear in mind that in certain infected cases there could well be a necessity to re-treat at not less than 14 days. This is to allow any viable eggs to hatch into live lice. This is not considered 'prevention'.

Teach Head Lice a Lesson

Follow Rotational Policy with Seton Healthcare's range of proven head lice treatments

PRESCRIBING INFORMATION: CARYLDERM Lotion, FULL MARKS Lotion, PRIODERM Lotion, SULEO C Lotion, SULEO M Lotion, DERBAC-C Liquid, DERBAC-M Liquid, PRIODERM Cream Shampoo and CARYLDERM Shampoo. **Indications:** CARYLDERM, FULL MARKS, PRIODERM, SULEO C and SULEO M Lotions, DERBAC-C and DERBAC-M Liquids, PRIODERM Cream and CARYLDERM Shampoos. Treatment of head lice infestation. **Active ingredients:** CARYLDERM Lotion: carbaryl 0 5% w/v. FULL MARKS Lotion: phenothrin 0 2% w/v. PRIODERM Lotion: malathion 0.5% w/v. SULEO C Lotion: carbaryl 0 5% w/v. SULEO M Lotion: malathion 0.5% w/v. DERBAC-C Liquid: carbaryl 1.0% w/w. DERBAC-M Liquid: malathion 1 0% w/w. PRIODERM Cream Shampoo: malathion 1 0% w/w. CARYLDERM Shampoo: carbaryl 1 0% w/w. **Dosage and Administration:** *Lotions and Liquids:* Sprinkle onto dry hair and rub gently into the scalp until all the hair and scalp are thoroughly moistened. Allow the hair to dry naturally and leave for at least 2 hours (12 hours for DERBAC-C and DERBAC-M Liquid). Shampoo the hair as normal. Rinse and comb whilst wet to remove dead head lice and eggs. *Shampoos:* Wet the hair thoroughly and apply enough shampoo to work up a rich lather over the entire scalp. Leave for at least 5 minutes, rinse and repeat. While the hair is still wet, comb with an ordinary comb, then a fine-toothed comb to remove dead lice and eggs. This treatment should be carried out a total of three times at three-day intervals. **Contra-indications, warnings etc.:** Not to be used on infants under 6 months of age except on medical advice. Avoid contact with the eyes. Skin irritation can occur (Lotions only). These treatments may affect permed, bleached or coloured hair. Do not use these products if you are sensitive to any of the active ingredients. CARYLDERM, FULL MARKS, PRIODERM, SULEO C and SULEO M Lotions contain isopropyl alcohol which may exacerbate asthma or eczema. As they are also flammable, apply to the hair with care and do not use artificial heat. **Legal Category:** P. (Carbaryl should only be dispensed against prescriptions) **Prices:** FULL MARKS and PRIODERM Lotions 55ml £1 93 R S P. £3 39. 160ml £4 27 R S P. £7 49. DERBAC-M Liquid and SULEO M Lotion 50ml: £1 93 R S.P. £3.39, 200ml £4 84 R S P. £8.49. DERBAC C Liquid and SULEO C Lotion 50ml £2 10 R S P. £3 69, 200ml £5 33 R S P. £9 35. CARYLDERM Lotion 55ml: £2 10 R S.P. £3 69, 160ml £4 70 R S P. £8.25. PRIODERM Cream Shampoo 40g: £2.14 R.S.P. £3.75; CARYLDERM Shampoo 100ml: £3.13 R S P. £5 49. **Product Licence Numbers:** CARYLDERM Lotion PL 0337/0038. FULL MARKS Lotion PL 011314/0047. PRIODERM Lotion PL 011314/0052. SULEO M Lotion PL 011314/0055. SULEO C Lotion PL 0337/0208. DERBAC-C Liquid PL 0337/0203. DERBAC-M Liquid PL 11314/0046. CARYLDERM Shampoo PL 0337/0044. PRIODERM Cream Shampoo PL 0337/0051. **Product Licence Holders:** FULL MARKS, PRIODERM, SULEO M, DERBAC-M: Seton Products Limited, Oldham OI1 3HS. CARYLDERM, DERBAC-C, SULEO C: Napp Laboratories Ltd , Cambridge Science Park, Milton Road, Cambridge CB4 4GW, UK. **Date of Preparation:** August 1996. Carylderm, Full Marks, Prioderm, Suleo and Derbac are Trade Marks of Seton.

Seton Healthcare Group plc

Beat the manpower trap

Nurturing a preregistration graduate may be the best way to beat the manpower shortage

Visiting schools of pharmacy and employing pre-registration graduates – getting them involved in the business, giving training and offering good incentives – may be what is needed to recruit good-quality pharmacists.

This was the consensus view of pharmacists attending a conference for small multiples organised by Bayer at the start of the month (*C&D* October 12).

In a novel 'round consultancy', participants were able to ask each other for advice about an issue of importance in their own business. There were other questions asked, highlighting the concerns of the small multiples.

- How do I add value as a pharmacist to an ethical manufacturer and GP, so that they see the pharmacist as vital to the healthcare team and want to involve me in their future?
- What are your priorities in increasing your gross profit?
- What should be audited to see if a prescription collection and delivery service is cost-effective?
- Is a central distribution system cost-effective?
- What measures would you employ to reduce/remove ethical stock wastage?
- How do I get pharmacist managers away from being more than just pharmacists – for example, retailers?
- What do you think should be the retail product categories in pharmacy?
- I need to improve security for my stock but still have my products on display and have good access to my customers. Ideas...?
- Is auto-labelling supplying all the information that you require?

It was evident from the advice given on to how to recruit high-calibre pharmacists that most proprietors are facing the same problems. Besides recruiting pre-registration graduates – suggested in eight out of nine replies – other ideas included:

- using recruitment agencies to head-hunt or poach pharmacists
- offer share options
- attract pharmacists by raising the company profile, give good job satisfaction and the opportunity for training in a controlled environment – financial reward alone may not be as effective
- consider employing pharmacists from overseas by advertising in foreign pharmacy journals.

One of the criticisms of head-hunting was that it can fail due to the recruit adopting an arrogant 'you need me' attitude.

Aiming to sell

To promote an effective OTC range, the consumers' shopping needs should be targeted.

This was the view of David Vanns, retail operations manager of the Doncaster-based pharmacy chain H I Weldrick. He gave a presentation on selecting, presenting and marketing an effective OTC range.

Mr Vanns believed it necessary to focus the range of products in the shop. The core range should include OTC medicines, baby care, personal care and health supplements. The niche ranges include fragrances, sports and alternative medicines.

Devoting more space to high-volume lines by giving them multiple facing could be important, but Mr Vanns thought that total category margin was more important than individual products' PORs.

David Vanns: "have a core range"

Price is the most important factor for only 28 per cent of customers. Even so, retailers should be aware of competitors' prices on known value items and "aggressively price monthly promotions".

- "From a commercial perspective, the pharmacist may be in a pivotal position to affect a pharmaceutical company's business," said Bayer's commercial accounts manager, Nick Simpson. Small multiple pharmacy chains collectively represent nearly 10 per cent of the UK pharmacy market.

The hottest news for p

Warner-Lambert is driving business into pharmacies by launching a Pharmacy-only multi-symptom Hot Drink to treat cold and flu

Benylin Four Flu Hot Drink is capitalising on the success of the Benylin Four Flu range, further extending pharmacy business and offering sufferers a powerful four-way action to treat the main symptoms of flu in the popular format of a hot drink.

Sales of hot drink remedies currently equal those of liquid and tablet formulations combined, but GSL products dominate the hot drink sector, so leaving pharmacists vulnerable to repeat purchase in non-pharmacy outlets. As trends show consumers trading up to multi-symptom cold and flu remedies, the launch of a Pharmacy-only, top-efficacy drink will substantially benefit the pharmacy and offer a serious flu treatment in the hot drinks market.

The launch of Pharmacy-only Benylin Four Flu in 1994 helped to stimulate substantial growth in the pharmacy cold and flu market, with pharmacy growth of 26.7 per cent between 1993 and 1995, coming, in part, at the expense of grocery.

Product development

Launched just two years ago, Benylin Four Flu became a major player in the cold and flu market in its first season with liquid and tablet formats. This success can be attributed to two factors: trial, which was generated by pharmacy recommendation and consumer demand following advertising; and repeat business, proof that the product works. Benylin Four Flu Hot Drink will be following the same successful formula, building on proven consumer demand and complementing the existing range.

The development of Benylin Four Flu Hot Drink was influenced by comprehensive research of all aspects of the hot drinks market. Hot drinks remains the cold and flu remedy format sufferers turn to most often, while lemon is consumers' preferred flavour, accounting for 80 per cent of sales. In taste tests, triallists revealed a preference for Benylin Four Flu Hot Drink over its nearest competitor. The tests also specifically revealed the lack of bitter after-taste with the new Hot Drink and a 'more medicinal' flavour than the benchmark product.

Benylin Four Flu's proven heritage, together with thorough research, has paved the way for pharmacies to profit from new Benylin Four Flu Hot Drink. The combination of Benylin Four Flu's proven track record, the popularity of hot drinks, and the efficacy and strength of this powerful, Pharmacy-only product offers substantial commercial potential to the pharmacy.

Endorsement

Benylin Four Flu is the most recommended of any cold and flu brand in pharmacy and, in only its second season, has taken the number two sales position in the 'serious' cold and flu treatments sector.

Jon Connolly, senior product manager at Warner-Lambert Consumer Healthcare, explains: "Consumers have already turned

harmacies this winter

Support

The launch of Pharmacy-only Benylin Four Flu Hot Drink illustrates once again the brand's commitment to pharmacy business. This is underpinned by a £1.9 million national television advertising campaign to be broadcast over the cold and flu season. The new advertisement, building on the current 'bed and bars' campaign, clearly communicates the additional benefits of the new Hot Drink and the unique relief it offers.

In-store, a comprehensive merchandising package has been devised to raise awareness of Benylin Four Flu Hot Drink. This will attract consumers into pharmacies away from GSL cold and flu remedies, to this Pharmacy-only alternative.

Innovative counter display units, shelf edgers and giant cartons have all been specially designed to maximise impact in the pharmacy and are available from Warner-Lambert territory managers.

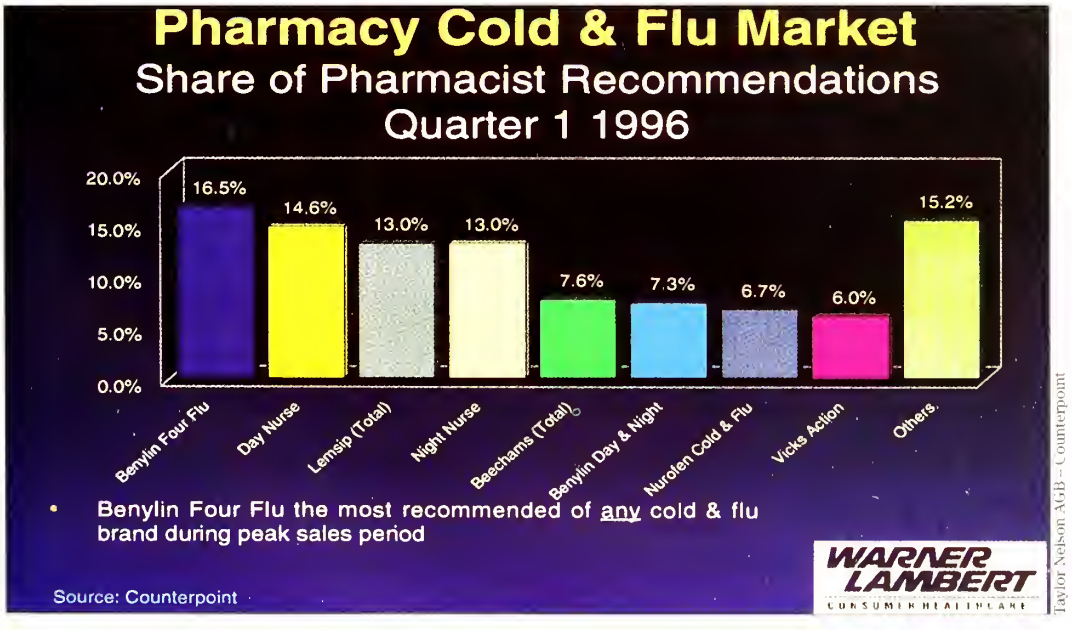
to Benylin Four Flu with its powerful four-way action. The introduction of a Hot Drink provides consumers with the best of both worlds – all the proven efficacy of Benylin Four Flu and the soothing benefits of a pleasant-tasting hot lemon drink – so providing pharmacists with a strong base for recommendation.

"As consumer data shows demand for serious cold and flu remedies and the continued popularity of hot drinks, Warner-Lambert is opening the door for pharmacies to take a greater slice of the business."

Success

Benylin Four Flu continues to out-perform all other cold and flu remedies, with sales growing at a rate of 55 per cent year on year[1] and taking 10.5 per cent of the pharmacy market[2] during the peak sales period. The launch of the new Hot Drink is set to continue this trend, targeting the mass of current hot drinks users. Hot drinks already account for 30.8 per cent of sales within pharmacy[3] and the introduction of Benylin Four Flu Hot Drink will provide credible flu relief in this format and so boost the hot drinks sector.

Benylin Four Flu Hot Drink is available to consumers in boxes of either five or ten sachets, priced at £2.35 and £3.99 respectively.



Taylor Nelson AGB – Counterpoint

References

1 A C Nielsen: year to June, 1996 v year to June, 1995.

2 A C Nielsen: January/February, 1996.

3 A C Nielsen: year to June, 1996.

Product Information **Presentation:** Each sachet contains paracetamol 1,000mg, diphenhydramine hydrochloride 25mg and phenylephrine 12mg as a pale yellow powder for reconstitution. **Uses:** For the relief of colds and flu; including coughing, fever, headache, muscular pains and congestion. **Dosage and Administration:** Adults and children over 12 years: One sachet dissolved in water every 4-6 hours, with a maximum of 4 sachets in a 24-hour period. Children under 12 years: Not recommended. **Contra-indications:** Known hypersensitivity to any ingredient, severe hyperthyroidism, hypertension or coronary artery disease and in individuals taking or who have taken an MAOI within the last two weeks. Avoid in individuals with narrow angle glaucoma or symptomatic prostatic hypertrophy. **Warnings and precautions:** Contains paracetamol, do not exceed the maximum stated dose. Patients should avoid any other product containing paracetamol while taking this medicine. May cause drowsiness, if affected do not drive or operate machinery. Avoid alcoholic drinks. Use with caution in patients with moderate hypertension, heart disease, diabetes, hyperthyroidism, elevated intra-ocular pressure, prostate enlargement, moderate to severe liver disease or kidney disease and in those receiving other medication which might interact with this product. Do not use in pregnancy or lactation. Use with caution in individuals with phenylketonuria. **Adverse effects:** Adverse effects are uncommon at normal dosages. Paracetamol can cause skin rashes and other allergic reactions rarely. Phenylephrine may give rise to nervousness, restlessness, dizziness and tremor in some individuals. Diphenhydramine can cause drowsiness, dizziness, blurred vision, gastro-intestinal disturbances, dry mouth, nose and throat, and urinary retention. **Legal category:** P. **Marketing Authorisation Number:** PL0018/0231. **Marketing Authorisation Holder:** Parke, Davis & Company, Usk Road, Pontypool, NP4 0TH. **Distributed by:** Warner-Lambert Consumer Healthcare, Lambert Court, Eastleigh, Hampshire SO53 3ZQ. **Cost:** rsp (excl VAT) five sachets £2.00; ten sachets £3.40. **Date of revision:** May, 1996. **Date of preparation:** August, 1996 (G728).

Looking to the future

Pharmacy in the New Age and the New Horizon documents were the focus of last Tuesday's session at the Unichem conference in Bermuda. The speakers represented a range of pharmaceutical organisations – the Royal Pharmaceutical Society, the NHS Executive, the Pharmaceutical Services Negotiating Committee, the National Pharmaceutical Association and the Guild of Hospital Pharmacists.
The conference was closed by David Mair, conference chairman and deputy chairman of Unichem, who briefly summarised the week's highlights and thanked the speakers. He paid tribute to Tony Foreman, the convention organiser, Soler and Studio B for the smooth running of all events, and looked forward to meeting many of the delegates at the company's 1997 convention in Malta.

No danger for the New Age

Opening his speech with quotes from the Nuffield Report, published ten years ago, chairman of the Pharmaceutical Services Negotiating Committee Wally Dove suggested that many of the challenges contained in that document had still not been met.

Although he made it clear he was not the "new danger for the New Age", he said that from the PSNC's perspective, Pharmacy in a New Age (PIANA) had bad points as well as good.

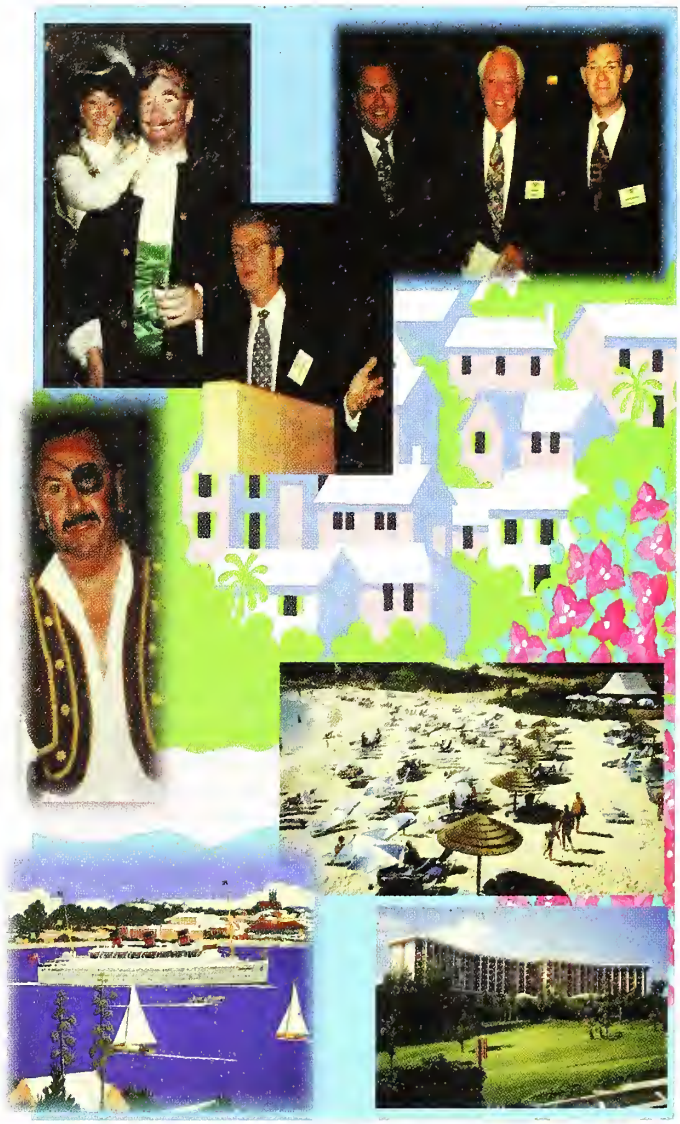
He was "pretty appalled" by the way the document approached remuneration. It struck him as being "at once arrogant, naive and sometimes suicidal". He did not believe it was helpful to invite bodies from outside the profession to "tell us how our remuneration system should change".

The proposals on doctor dispensing he described as "equally worrying". Rather than proposing new initiatives or unilateral approaches to the medical profession, he believed it would have been more helpful if the Society continued supporting work that was already in train.

He implored the Society to "tailor its ambitions to its abilities and responsibilities" and urged it not to neglect its responsibilities in an effort to take over matters dealt with by others.

He told delegates that the PSNC had been "carefully examining ways of changing and improving the system to reflect and reward the extended professional service that contractors want to provide in the future. I happen to think it's best done quietly and methodically before encouraging the world and its mother to pitch in".

According to Mr Dove, "One of the crucial roles of the Society is to improve the standing and the performance of the profession by the strict enforcement of a stringent code of conduct and high standards for premises." He went on to say that "it's about time that the Society acted to ensure higher standards throughout community pharmacy so that the vast majority are no longer let down by a small but visible minority. If community pharmacy is to seize the professional initiatives which PIANA talks about, it surely has to do more to put its house in order".



As for the future, the PSNC would be focusing on the following core objectives:

- defending and enhancing the value of the existing community pharmaceutical service, as well as seeking out new ways of developing the remuneration system to provide adequate resources for new services
- ensuring that the public continues to enjoy ready access to the NHS pharmaceutical service and the expert advice of the pharmacist
- exerting its influence to ensure that the case for proper resources is not undermined by inconsistent standards of premises and conduct
- maintaining a nationwide service, which delivers the same high standards of care and service to the public in every rural and urban community.

Pharmaceutical care in easy reach of every patient

Tim Astill, director of the National Pharmaceutical Association, congratulated Ann Lewis for sowing the 'New Age' seeds during her two-year presidency of the Royal Pharmaceutical Society. "Whether they grow to fruition remains to be seen," he added.

In his presentation, Mr Astill combined a personal view of the way pharmacy should be thinking for the future and a selection from the 'New Age' document.

He expressed his dissatisfaction that under the current system of pharmaceutical care in relation to supply of medicines, any contact between pharmacist and prescriber was usually in the context of confusion or possible error on the prescription, and that no one knew if the patient was taking the medicine.

He told the conference that "if the healthcare system is to make maximum use of the pharmacist's knowledge and expertise in medicines, there should be systems that result in the pharmacist being involved from the moment that drug therapy becomes one of the options. There should be a means whereby the prescriber has access to pharmaceutical advice at the point of prescribing and in the preparation of a formulary, as well as a mechanism for enabling pharmacists to manage patients and their medicines after the patient has left the pharmacy".

He would like the Council to concentrate on enabling community pharmacy to evolve so as to bring pharmaceutical care within much easier reach of prescribers and ultimately every patient. His own definition of pharmaceutical care was: "The application of the pharmacist's training, knowledge and experience to ensure that patients gain the maximum possible benefit from the most cost-effective use of medicines."

Although much had been done to raise public awareness of the pharmacist's expertise, Mr Astill told delegates that "there is still a very long way to go".

He expressed his concern that the 'freelance pharmacists' in the New Horizon document might 'cherry pick' services and strongly advocated patients getting their pharmaceutical services from 'their' community pharmacist.

He finished by offering his support to the Council in its "uphill struggle to convince those who hold the purse strings that investing in pharmacy would generate substantial returns in the form of improved patient outcomes and better quality of life".

Meet the future challenge

"The future has challenges and opportunities for pharmacy whether it be in hospital or community," Chris Cairns, president of the Guild of Hospital Pharmacists, told conference. "If we do not meet the challenge and turn it into an opportunity, there are others who will step into our shoes and take our future from us."

The New Horizon was favourable towards the continuing role of hospital pharmacists, with specific reference to issues such as guiding colleagues in the use of medicines, taking responsibility for medicine use and the recommendation that pharmacists should manage the pharmaceutical care of patients.

He suggested that hospital pharmacy was in a strong position in relation to pharmacy as a whole because it had changed considerably over the past 30 years. Changes such as the shift from traditional dispensing and distribution to much more active and advisory roles as part of multi-disciplinary teams were driven and implemented by pharmacy practitioners and pharmacy managers in the hospital service – not by the Royal Pharmaceutical Society, the Department of Health or the Schools of Pharmacy.

However, he admitted that pharmacy in hospital couldn't be complacent as other members of the healthcare team were looking to develop their roles, and secondary healthcare delivery had changed dramatically over the last ten years. "The new model of care delivery will involve smaller, busier, more demanding tertiary centres with a high proportion of their activity orientated around day surgery and diagnostics, which will mean different and more intensive demands on the pharmacy department," he said. "It will be the primary care team, led by the GP, which will actually drive health service provision."

In many hospitals, pharmacists were beginning to take over the discharge medication prescribing role, and Mr Cairns believed that within five years nearly every discharge prescription in a hospital would be managed totally by pharmacists.

Mr Cairns saw the way forward as an opportunity for partnership between the various components of the pharmacy profession, community, industry and wholesalers.

Crossing distant shores of opportunity ...

"Much of the legislation that surrounds and defines our profession is based on a presumption of a role which was traditional at the time when I qualified but is no longer exclusively so," Bryan Hartley, chief pharmacist of the NHS Executive, told delegates.

The remuneration system was founded when the professional task was exclusively preparation and dispensing, but now it was incentive, he said. Not surprisingly, the need to review alternative remuneration structures for community pharmacy services was picked up in New Horizons.

However, Mr Hartley pointed out that there must be a balance between developing services that would be part of the core role and paid out of money ring-fenced for pharmaceutical contractors (Part 2 funds), and services devolved to health authorities and service development, which would have access to so-called Part 1 funding. This Hospital and Community Health Services funding, most of which was committed year on year, could be used to fund extra contractual services.

Projects funded by Part 1 money faced the risk that they might not be continued, even where a desired outcome was reached. Part 1 money was not ring-fenced and, each year, HAs had to adjust their spending plans according to their budget.

He asked the audience: "Are you prepared to meet the challenges to gain this professional future?" They were told it meant "leaving the safe dispensing shore – hoping not to be overcome by competitors for current and future roles – to take major risks posed by the crossing, during which there could be losers, to gain the opportunities offered on a distant shore".

At this stage his concern was "to establish the extent to which contractors have ownership to the changed agenda and aspirations set out in New Horizons. Because if there is substantial commitment to the change, there are excellent opportunities".

... and seeking out the New Horizon

Ann Lewis, the immediate past-president of the Royal Pharmaceutical Society, presented the key elements of the strategy for the profession and an action plan as covered in the New Horizon document.

Respondents to the PIANA initiative had identified knowledge and availability as the two major strengths of pharmacy. They felt that the profession should provide more services, such as advice and counselling, health promotion, health screening and prescribing, as well as improving relationships with other healthcare professionals.

Areas suggested for contraction included routine aspects of dispensing and sales of non-health-related products.

Many respondents commented on the need for the nature and take-up rate of continuing education to change.

One of the most common requests was for high professional standards – for premises and professional ways of working.

Issues within Council control that it was asked to address included continuing education, maintaining high standards, practice research and audit, and the undergraduate courses.

Other issues on which the Society might wish to campaign included remuneration, unifying the profession, developing information technology and POM to P shifts.

According to Ms Lewis, the four main areas where pharmacists' contributions to health outcomes would be vital were: management of prescribed medicines, management of chronic conditions, management of common ailments, and promotion and support of healthy lifestyles.

The New Horizon documented what the Council planned to do in the next year. The programme of 22 specific commitments were set out under five themes: maximising pharmacy's contribution to better health; improving accessibility, efficiency and availability of pharmacy services; remuneration (joining with other bodies in a review of alternative remuneration structures for community pharmacy); achieving life-long learning; and seizing the professional initiative.

Damned with faint praise

May I thank the author of **Northern Ireland Notebook** and all the other pharmacists who recently voted me onto the Pharmaceutical Society of Northern Ireland Council.

Young, dynamic and courageous are not adjectives I usually use to describe myself (my children found 'young' particularly amusing), but then I don't know who writes **NI Notebook** – maybe I am young, dynamic and courageous compared to him/her!

Having read the column last week (*C&D* October 5, p455) and chatted to Terry Hannawin, I see years of unappreciated hard work, long meetings, late nights and faint praise to damn me at the end of my term, if I'm lucky.

Am I worthy of your vote? I hope so. All I can promise is I will try to be.

Kate McClelland
Maghaberry

Cock-up or conspiracy?

The 'Persona' controversy (*C&D* October 5 and 12) embodies both 'cock-up' and 'conspiracy'.

The 'conspiracy' angle sees Boots cornering a new market to the exclusion of the rest of the profession. However, Unipath's actions, I suspect, fall into the category of good, old-fashioned 'cock-up'. I truly believe that the company was unaware of the hornet's nest it would stir up.

Nevertheless, the remarks by Hubert Lafont, Unipath's vice president of sales and marketing, are somewhat disingenuous to say the least. Mr Lafont claims that the Persona starter-pack is selling in Boots "at virtually no profit". He fails to mention whether there was a cash payment made to Boots in order to gain both its support for the product, and for all the training. Neither does he mention the value to Boots of all that free publicity.

Does he really believe that the independents will happily enter at phase two of the launch to support the sale of Persona refills, thereby merely 'gleaning crumbs from the rich man's table?'

I would also question the logic of Unipath's choice of Boots in the first place. Will people feel comfortable discussing the details of their sex lives in the large store atmosphere of the average Boots' branch? Surely the cosy but professional independent pharmacy is a more likely setting?

I have sought advice from the NPA, which has indicated such a distribution arrange ment is not, in current circumstances, a restraint of trade. But Unichem has placed an order for the product which will test Unipath's resolve. In the meantime I have withdrawn my support for Unipath's pregnancy test.

Graham Phillips
St Albans
(See also 563)

A call to take action

I have been away at the party conferences lobbying for the retention of RPM, and so have only just read about the Boots/Unipath collaboration. No one can blame Boots – without the manufacturer's co-operation we would have had a normal distribution pattern.

Unipath must think that independent pharmacists are both naive and stupid. This week, my pharmacy received a bonus offer on Clearblue: what a coincidence! But like Harry Ganz and Nucare, the product is off my shelves.

Does the company expect us to seriously believe that only Boots' pharmacists are capable of being trained – what rubbish! Follow our example to show other manufacturers the risk they take.

David Sharpe
London NW7

All on our own

From the Pharmacy Support Group's latest utterances on the professional allowance, we are led to believe that the majority of community pharmacists believe pharmacy politicians to be evasive, mendacious and almost totally partisan. This mood is unpleasant and also potentially dangerous.

Alienated from existing organisations these pharmacists are out to relieve their frustrations by backing aggressively anti-system groupings.

From our Society's regular elections, many apathetic voters have withdrawn into a kind of solemn non-co-operation, not so much hating established institutions, as dismissing them.

What accounts for the sourness of today's mood? Before the two major legal challenges to our Society's powers (Jenkins' and Boots' judgments), there seemed to be a prevailing set of ideas and ideals that structural pharmaceutical debate provided guidelines for policy and hope for the future.

Since these two major fault lines, no new dominant doctrine has arisen. In short, our leaders – sublime and subordinate, but who claim to be in command of events – are no longer plausible, and community pharmacists sense it.

It is a bleak reflection of modern pharmacy that anyone who challenges the fashionable attitudes of the vociferous minority is often branded as being out of step. This is a form of suppression of freedom of speech.

It is lamentable that the continued publishing of such views should give credence to minority views. There must and should be open and free debate on the question of negotiating our remuneration with the Department of Health. There is nothing new in small pharmacy owners venting their spleens in indignation because they feel they may have just been ignored or neglected. One has to be in step with so-called progress and out of step and isolated on your own.

David Thomas
Wolverhampton

Anything Boots can do ...

I read with interest *C&D* October 5 concerning Boots' tying in of health promotion activities with national awareness campaigns.

Independent pharmacists wishing to engage in similar initiatives may be interested to know that Inphorm can offer them the chance to provide a service that is far more comprehensive than the one being promoted by Boots.

We can obtain any of 2,000 different leaflets, covering over 80 subjects, as well as accessing an extensive video library of over 600 titles. If anyone would like further details, then can contact our 24-hour answer machine on 01457 874990.

Michael Johnson
Director, Inphorm

Unite against Unipath?

What action will Unichem, AAH, Lloyds and others take with the sales and distribution of Unipath's products now that it has found a partner worthy of trading with?

All small multiples and independent pharmacies should unite for a show of strength and decide upon a stock policy. What a cheek Unipath has to send 'Autumn Radio Campaign Extra Offer'. Better to send it off to Boots and save an expense.

S L Pabari
Dagenham

Sants links with George Foster

Sants and George Foster, the independent wholesalers based in north England, have become partners to strengthen their position in the market.

Foster is a full-line pharmaceutical wholesaler that serves north west England from a single depot in Burnley. Sants covers the North West and West Midlands from its 48,000sq ft depot in Newcastle-under-Lyme. Both deal with about 1,000 independent pharmacists.

Under the agreement, Foster has the option of acquiring just under 50 per cent of Sants' shares. It can take this up anytime between January 1 and June 30 next year.

Foster has offered to lend Sants £250,000. The latter says it could use the loan as working capital and to upgrade its computer systems.

Gerald Brooks, Sants' chairman and chief executive, says the partners have been close since 1991, but they began negotiating this agreement at the beginning of the year.

Foster's annual sales are estimated at £60 million, which is much more than those of Sants, but the latter claims it has the largest independent wholesale warehouse in the UK with considerable excess capacity.

Mr Brooks says the partnership makes sense, given the climate of concentration in the pharmaceutical wholesale market. "I think it's in the interest of the market to have a strong, independent wholesale operation on this side of the UK," he says.

The partners are not interested in diversifying into retail pharmacies, he adds, but will concentrate on their core wholesaling strengths. Both will benefit from synergy. "There's scope for shared management expertise and we'll co-operate to develop our strategy."

While Mr Brooks does not rule out a merger between the two, he says it is unlikely in the short-term. Other independent wholesalers, he adds, ought to consider doing something similar.

"We've heard so much talk about the need for a third wholesaling force in the UK, but the UK already has such a force – independent wholesalers."

Gerald Brookes

Stafford-Miller buys Piriton

Block Drug Company, Stafford-Miller's US parent, has acquired Piriton from Glaxo Wellcome for an undisclosed sum.

Stafford-Miller says the acquisition takes effect from the beginning of November and it aims to launch an advertising campaign for the brand early next year.

Piriton joins the company's growing OTC portfolio, which includes Settlers, acquired last year from Smithkline Beecham, and Nytol.

Pharmacists with further queries should contact their Stafford-Miller representative or the company on 01707 331001.

Fotostop unveils its ambitious expansion plans

The Fotostop Group plans to increase its sales to £30 million by 1999, following a multi-million pound deal with Lloyds Development Capital – the venture capital arm of Lloyds Bank.

Under the agreement, LDC has lent Fotostop several million pounds, although the exact figure remains confidential, and has taken a minority stake in the company.

Charles Gabriele, Fotostop's co-owner, has partly used the cash to buy out his partner, Mario Swanston. Mr Gabriele is now group managing director and, with Cathal Maye, assistant group managing director, heads a new team of managers.

The rest of the money will finance an expansion plan – about 330 retailers currently use Fotostop's minilab facilities and accessories.

Clive John, a director at LDC, says its research suggests that Fotostop is a worthwhile investment. "We're very selective in the investments we make, and we looked long and hard at the business [Fotostop] before we decided on the investment."

New Acts will increase red tape

Three new Acts coming into effect in the next few months are set to add to the volumes of red tape affecting small businesses.

Under the Immigration & Asylum Act, which comes into effect at the beginning of January, pharmacists who employ foreign pre-registration graduates (even if they have trained at a UK school of pharmacy) have to ensure that people they recruit are allowed to work in the UK. They are advised to ask for documentation – such as a P45, national insurance card, birth certificate or passport – before taking on employees. Employers who take on illegal immigrants face a fine of up to £5,000.

The Disability Discrimination Act 1995, which becomes effective on December 2, makes it unlawful to discriminate against disabled people in terms of recruitment, and contract and employment.

Discrimination in the following areas will be unlawful: mobility, manual dexterity, physical co-ordination, continence, ability to lift, carry or otherwise move everyday objects, speech, hearing or eyesight, memory or the ability to concentrate, to learn or to understand.

Under the health and safety law, employers are now required to consult employees on health and safety matters. This means that regular meetings with employees are required.

Boots to plough £37.6m into new overseas stores

Boots' overseas expansion has begun with a vengeance, with a pilot store scheme set for Thailand, the Netherlands and Japan. New shops are also planned in the Republic of Ireland.

The company is investing £30 million over the next 18 months for its pilot stores.

For the Thai market, it has formed a joint venture with the Minor Group, a company with in-depth knowledge of Thailand's retail market, to open four stores in Bangkok and one in Pattaya. Boots expects the outlets to be completed by next summer.

Each will be 150-700sq m in size and the layout will resemble closely those in the UK. All will have a pharmacy, which will handle prescription and OTC medicines. They will also stock a wide range of fragrances, cosmetics and toiletries.

The Thai partnership will be headed by Martyn Bell, previously merchandise and marketing director of Halfords, a Boots' subsidiary.

Boots will open three outlets in the Netherlands, where it has an agreement with Eerstelijns Voorzieningen Almere to provide in-store pharmacy services, including prescriptions and OTC medicines. EVA provides primary healthcare for the Almere region.

Boots' Dutch stores will resemble their Thai equivalents, but their average size will be 1,000sq m, one-fifth of which will be devoted to pharmacy. The operation will be led by Peter Stone, formerly director of store planning at Boots the Chemists.

The company is expected to announce its plans for Japan shortly.

Unichem tests Unipath by placing order for Persona

Unichem has placed an order for Persona, the fertility testing device that is currently available exclusively to Boots.

Unipath, Persona's manufacturer, had yet to respond to Unichem's order as *C&D* went to press, but it is undoubtedly facing growing pressure to widen the product's distribution.

Two members of the National Pharmaceutical Association have also placed orders.

However, Tim Astill, the NPA's director, says it cannot do anything to persuade the manufacturer to change its controversial decision.

"There's no question that Unipath's exclusive agreement with Boots is wrong. The question is whether it is unlawful. Unless the agreement is designed to maintain a price unlawfully, it is not unlawful," he says.

As the deal was not designed to prop up Persona's price, he says, the NPA and the Office of Fair Trading have no grounds for legal action.

Freeman changes address

Freeman Pharmaceuticals has moved to: Freeman House, Cold Bath Road, Harrogate, North Yorkshire HG2 0NA. Tel: 01423 508800.

Relief on the Web

Panpharma has developed an Internet Web site for Movelat Relief. It also has information on arthritis and access to other related Web sites. Its address is: http://www.movelat.com

Popular vote

A record 78 per cent of MPs regard the pharmaceutical industry favourably, up 7 per cent on last year's figure, according to the Association of the British Pharmaceutical Industry. The politicians now place the industry fourth among their 36 most popular British industries.

S&N's Dermagraft in UK

Smith & Nephew looks set to launch Dermagraft, its treatment for diabetic foot ulcers, in the UK and the US during the second half of next year. The roll-out will proceed to other countries in 1998, as soon as the product receives regulatory permission.

Gehe to sell subsidiaries

Gehe is selling four drug manufacturing subsidiaries for about DM700 million ($458m). Stuttgart-based Azupharma has been sold to Sandoz for DM640m, while BASF is to buy GNR-pharma, Gehe's generic-drugs unit, based in France. Dieter Kämmerer, Gehe's chairman, reportedly says the sales will increase its financial freedom for another bid battle over Lloyds.

Unichem's spectacle scheme

Unichem is rolling out a spectacle dispensing service for independent pharmacists, following a successful pilot scheme in Guildford and Hull.

Delegates at the company's convention in Bermuda have already received a sneak preview of the service (*C&D* October 12, p498).

Spectacle sales are annually worth about $700 million and are growing by 7 per cent every year, according to Unichem.

Its pilot involved seven pharmacies in Guildford and ten in Hull. These could make a 50 per cent profit on return by dispensing spectacles, says Unichem. By selling two spectacles a week, a pharmacist's annual profits could exceed $1,500, and the wholesaler claims many could exceed that figure.

Each pilot pharmacist had a one-metre stand featuring 60 different pairs of spectacles, whose prices ranged from about $20-50.

When a customer arrived with a prescription, the pharmacist would make a measurement and send the information to a central laboratory. The finished spectacles were posted back to the pharmacist within 48 hours.

Unichem backed the pilot with in-store promotions, leaflet drops and advertisements in local papers. This marketing support accounted for about 50 per cent of the pilot's spectacle sales.

Martyn Ward, Unichem's director of sales and marketing, says customers responded well to the new service. "After all, if you can trust your pharmacist to dispense medicines, it's a small step to visiting your pharmacy for a new pair of glasses," he says.

The spectacles' prices are vitally important. "Our aim is not to pit pharmacists against opticians in a head-on battle. Clearly, opticians are qualified to perform eye tests and write prescriptions for spectacles. We're enabling pharmacists to dispense a pair of top-quality spectacles using a prescription from a qualified optician, at a much lower price," he says.

Unichem's roll-out is based on geographic regions, which have yet to be announced. Interested pharmacists should contact their local account managers.

The company has set up a specialist wholesale division, called Univision, for its new venture. This will be managed by Bob Forgan, a manufacturing optician; Michael Apps, a dispensing optician; Mr Ward; Mark Thomas, Unichem's director of corporate development; and Steve Duncan, Moss Chemists' marketing director.

Colourcare puts £10m into new technology

Colourcare plans to invest $10 million by the end of 1998 on new equipment and technology.

The photo processing specialist, which deals with about 4,500 independent retailers, including pharmacies, says it is preparing itself for the reviving UK market.

Between 1989 and 1994, the photo processing market's sales shrank by 12 million films, equivalent to about 25 per cent of its value. However, sales are picking up again and are expected to grow further with the relaunch of the Advanced Photo System for cameras and film processing – scheduled in time for the peak Christmas and New Year period – and the expansion of digital imaging technology.

APS, developed by the five major camera manufacturers, essentially involves new types of cameras and films that provide much better results than conventional 35mm versions. APS customers are also given a contact sheet that bears miniature reproductions of their photos, enabling them to choose prints for repeat orders.

The system was originally launched in March/April, but failed because the manufacturers had not produced enough film and cameras to meet global demands.

Colourcare says the manufacturers are now better prepared. By 1999, it says, APS cameras and film should account for 20-25 per cent of the UK photo processing market.

APS is about 50 per cent more expensive than 35mm and it has enormous profit potential for pharmacists, according to Jim Brown, Colourcare's managing director. Pharmacies need invest only a fraction on staff training and marketing. They can still take in both 35mm and APS film for processing, he says.

More than three tonnes of unwanted drugs were dumped at 74 police stations and 500 pharmacies in Greater Manchester, following a 'drugs dump' campaign run by the local police and backed by Zeneca Pharmaceuticals. The company promised to donate £1,000 to a Third World charity for every tonne of unwanted drugs collected. Its £4,000 cheque has been given to the Red Cross. From left, Mary Firth, high sheriff of Greater Manchester; Duncan Burke, Zeneca UK's professional relations manager; chief constable David Wilmot of the Greater Manchester Police; and Professor Graham Oats from the Red Cross

COMING EVENTS

MONDAY, OCTOBER 21

Derby Branch, RPSGB
Kingsway Hospital, 7.30 for 8.00pm. 'Modern infectious diseases' by Dr Mary Newlands.

TUESDAY, OCTOBER 22

N Metropolitan Branch, RPSGB
School of Pharmacy, Brunswick Square, WC1, 7.30 for 8.00pm. 'Pharmacy's fight to keep RPM' by Beverley Parkin, RPSGB.

WEDNESDAY, OCTOBER 23

Shropshire Branch, RPSGB
Albrighton Hotel, near Shrewsbury, 7.30 for 8.00pm. 'Aspects of terminal care' by Dr Jeremy Johnson of Shropshire Hospice.

Bath and District Branch, RPSGB
Pratts Hotel, Bath, 8.00pm. 'Osteopathy' by David Richardson, registered osteopath.

Southampton & District Branch, RPSGB
Southampton and SW Hants Health Authority, Southampton, 7.30 for 8.00pm. 'Latest developments in ophthalmic surgery' by A J Luff, Southampton eye unit.

Hertford and District Branch, RPSGB
Merck, Sharpe and Dohme, Hertford Road, Hoddesdon. 7.30 for 8.00pm. 'Update on meningitis' by Dr R Joce.

THURSDAY, OCTOBER 24

North Staffordshire Branch, RPSGB
North Staffordshire Medical Institute, Hartshill, Stoke-on-Trent, 8.00pm. 'Role of the Bionic Workshop' by Dr A Rahmatella, director Bionic Workshop Orthopaedic Research Unit.

Weald of Kent Branch, RPSGB
The Spa Hotel, Mount Ephraim, Tunbridge Wells, 7.45 for 8.00pm. 'Pharmacy: who gives a damn?' by Andrew Burr, member of Council.

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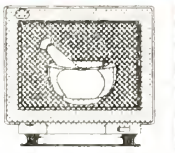

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TRADE LESS 30%+VAT - 72 Loron 520 tabs (exp 1/98), 3x28 diamox 250mg caps (exp 12/97), 4x30 Sandimmun 100mg (exp 3/99), 30 Sandimmun 25mg (exp 3/99), 30 Sandimmun 50mg (exp 3/99). Tel. 01268 552194.

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Free entries in "Business Link" (maximum 30 words) are restricted to community pharmacist subscribers to *Chemist & Druggist*. No trade advertisements will be permitted. Acceptance is at the discretion of the Publishers and depends upon space being available. Send proposed wording to "Business Link" using the form printed alongside.

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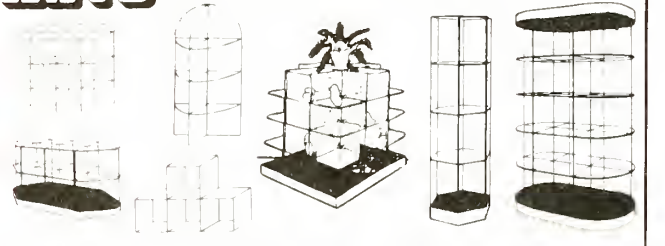

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ABOUTpeople

TOP tops its charity total

The Oshwal Pharmacists has raised a record-breaking amount of money for charity. Over £15,000 was presented at TOP's 16th annual dinner and dance in London recently, including £14,500 raised by the group in its annual charity walk in June.

Beneficiaries of the 'walk' money are the British Diabetic Association, Sight Savers International and the Oshwal Association of the UK. The bodies received £7,250, £3,625 and £3,625 respectively.

Guest of honour Royal Pharmaceutical Society president Ian Caldwell also received a cheque for £500 for the Commonwealth Pharmaceutical Association and £200 for the RPSGB Benevolent Fund.

Mr Caldwell praised TOP, saying: "Oshwal pharmacists have a well deserved reputation for benevolence and fellowship."

The Oshwal pharmacists pictured with Royal Pharmaceutical Society president Ian Caldwell at their 16th annual dinner and dance

A record turnout in recent years of over 250 guests saw the night out in style at the Ulster Chemists' Association's presidential dinner dance last Saturday at the Culloden Hotel, Craigavad. Among the guests of UCA president Peter Wright (second right)) were NPA chairman Peter Jenkins (second left) and director Tim Astill (right), and secretary general of the Irish Pharmaceutical Union Enda Ryan (left)

Bring on the marathon men

There will be 27,000 competitors running in the New York marathon on November 3. One thousand of them will be from the UK, and at least two have pharmacy connections.

D Chandegra, a community pharmacist from the Isle of Dogs, London, is seeking sponsorship to raise funds for the Newham Hindu Community Centre, a project of the Vishwa Hindu Parishad.

In 1988, Mr Chandegra completed the London Marathon and raised £6,000, mostly for the Imperial Cancer Research Fund. Anyone wanting to sponsor him on this occasion should send their donation to: 15 The Quarterdeck, Barkantine Estate, West Ferry Road, Isle of Dogs, London E14 8SH (cheques to Vishwa Hindu Parishad – Newham).

The New York Marathon will be the eighth for Ged Gilmartin, a relief driver at Unichem's Exeter branch. He will be running for the Cancer Research Campaign. This will be the first overseas venture for Ged, who has run in five London Marathons.

Chemex competition corner

Last month's Chemex saw several opportunities for pharmacists to win gifts.

Sorbie Research International, a supplier of compliance aids, offered three prizes of display stands with stock valued at £300.

The three winners of the Apex stands were Allen Mathewson, proprietor of Mathewson Chemist, Ballymoney, County Antrim; Mark Robinson of the Numark Pharmacy in Wilmslow, Cheshire; and Tina Cook at the Vantage Chemist in Sheffield.

Mr Mathewson is pictured (right) receiving the stand from SRI director Mitchell Sorbie.

Another Chemex winner was Paul Dishman of the St Thomas Pharmacy in Exeter. He won the magnum of champagne offered by John Richardson Computers and is pictured (top right) outside his pharmacy.

The Health Education Authority's folic acid draw was won by Jonathan Brown of Boots in Kingston-upon-Thames, Middlesex, and M Chin of Havehills Pharmacy, Leeds. Both answered the three questions posed by the HEA correctly and took away £50 Marks & Spencer's vouchers.

APPOINTMENTS

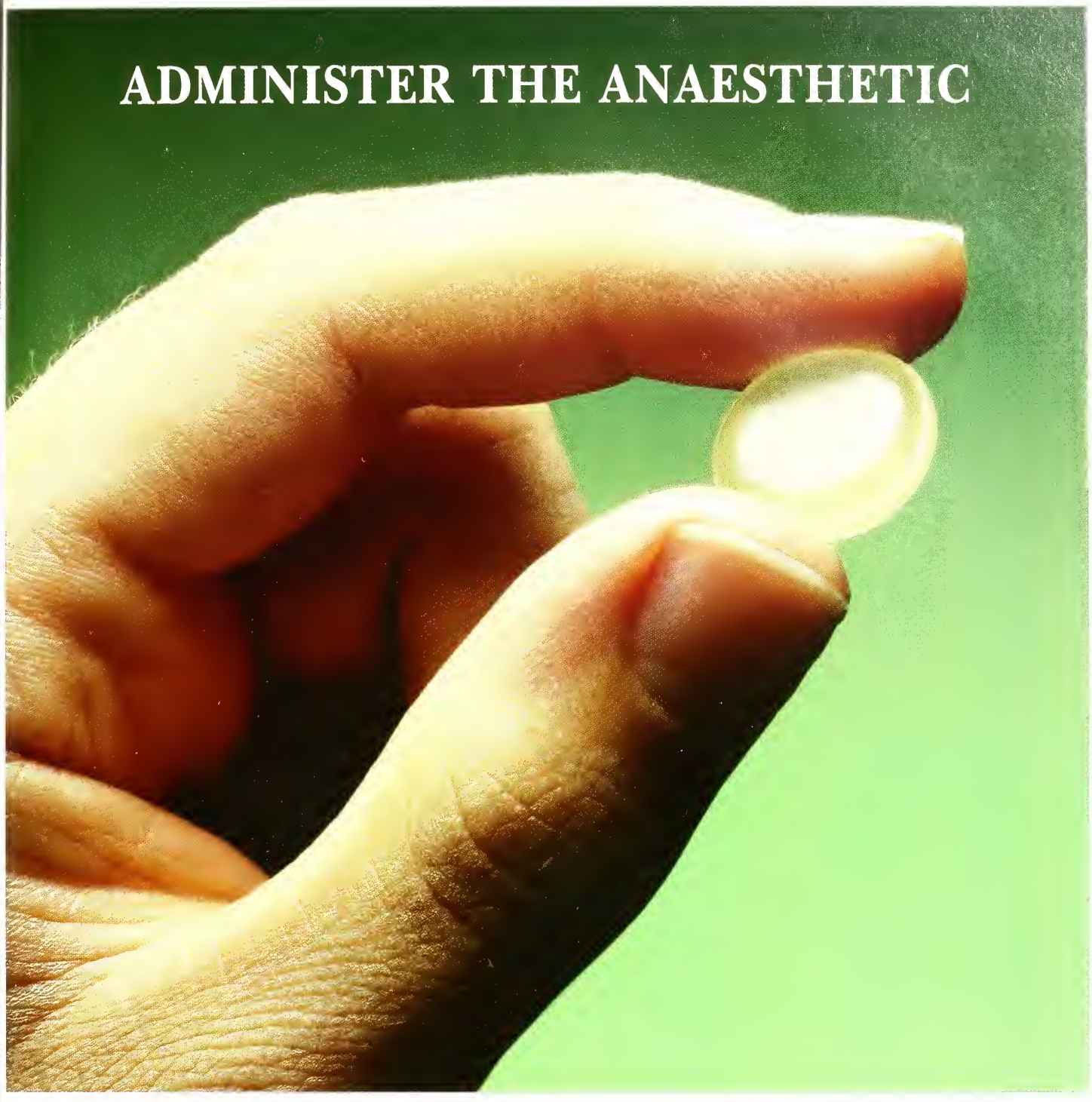
The new chief dental officer for England is **Robin Wild**, currently CDO in Scotland. He will take up the post in the new year, succeeding Brian Mouatt who is retiring.

Unichem has appointed **Michael Carey** as a senior OTC buyer, based at the company's Chessington head office. Coming from the British Tourist Authority, he will report to Gary Allmark, Unichem's over the counter buying controller.

Dr Martin Preuveneers has been appointed international operations director of British-based Cortecs International. He has held previous positions at the biotech company Therexsys and also at Glaxo Wellcome.

Frank Meysman, senior vice president of Sara Lee Corporation, has been made a non-executive director of the Zeneca group.

ADMINISTER THE ANAESTHETIC



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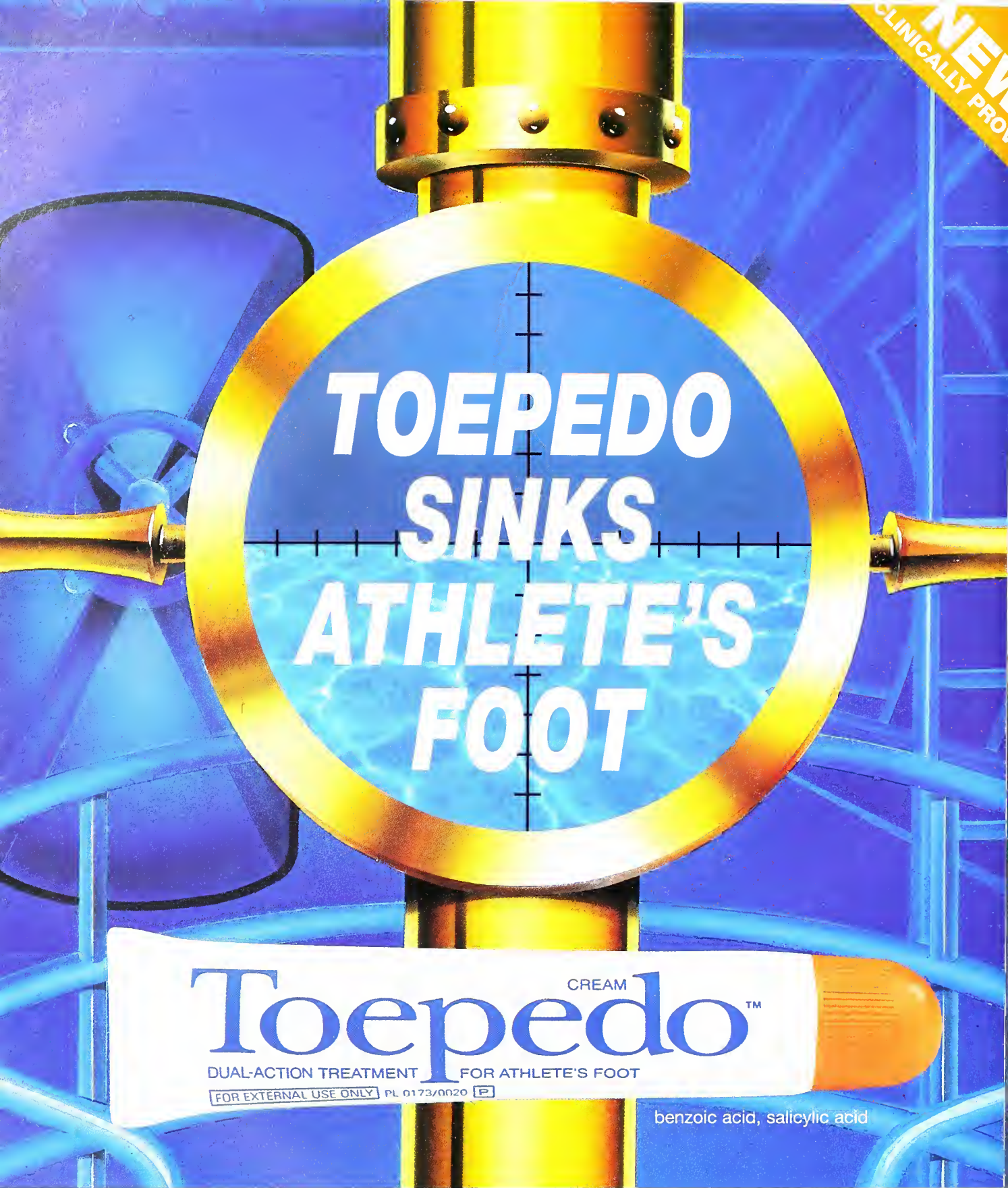
CROOKES HEALTHCARE



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